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ABSTRACT

Seven articles discuss components of parent programs in the early education of deaf and hard of hearing children which are thought to be applicable to parental involvement in almost all child development programs. Parent child and professional interaction is considered in terms of establishing a productive relationship with parents and facilitating parent child communication. Described are the parents' need for help and the teacher's role in providing emotional support in dealing with feelings, in following the prescriptions of professionals, and in developing realistic expectations and appropriate child rearing practices. Parameters of a systematic program for parent information (such as instruction in child development, handicapping conditions, behavior management, and intervention procedures, materials and equipment) are explained. Suggested are means of helping parents to become teachers, to recognize the learning opportunities offered in the home, and to realize the impact of their child on themselves and their family. Means of developing parent participation through roles as co-experimenter and observer and through group interaction with other parents are examined. Stages in the planning of parent programs are distinguished. Provided are annotations on scope, content, and main use of approximately 40 documents concerning emotional support, information exchange, parent child interaction, and parent participation. (GW)

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First Chance for Children is a series of monographs published for the First Chance Network. The subject matter is drawn from the knowledge, skills, and techniques of the people that work within the First Chance Network and is collected and published by the Technical Assistance Development System. Issues are available on request until the supply is exhausted.

In 1968 the enactment of the Handicapped Children's Early Education Act authorized the establishment and operation of model early education projects. The responsibility for administering this new program was accepted by the Bureau of Education for the Handicapped, Office of Education. The program is designed to develop and demonstrate effective approaches in assisting handicapped children during their early years and is structured so that other communities can replicate, or adopt, exemplary program components to meet their own needs.

The Bureau of Education for the Handicapped (B.E.H.) has as its overall goal the equalization of educational opportunity for handicapped children by providing the leadership and resources needed to help the handicapped achieve their fullest potential and participate constructively in society to their maximum abilities. The long-range objective of the Handicapped Children's Early Education Program is to stimulate services to all 1,000,000 preschool-aged handicapped children by the end of this decade.

Technical Assistance Development System (T.A.D.S.) was established in Chapel Hill, N.C. by B.E.H. to serve a supportive function for the network of centers. The role of T.A.D.S. in this system is to provide assistance in whatever phase of their program the centers request help. Some of the services include identifying and providing consultants, holding small group workshops, collecting and dispensing data about the network, and conferring with individual centers and staffs.

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PARENT PROGRAMS IN CHILD DEVELOPMENT CENTERS

Edited by David L. Lillie

first chance for children vol. I

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Preface

In December, 1971, a group of highly competent professionals in the field of early education for handicapped children were brought together by the Technical Assistance Development System, a component of the Frank Porter Graham Child Development Center at the University of North Carolina. The purpose of this meeting was to explore the dimensions of how to plan programs for parents of young handicapped children. By providing an opportunity for the surfacing and interchanging of the thoughts of a capable group of professionals, we believe that T.A.D.S. could make a contribution to the field. The membership of this group was largely comprised of professionals working with hard-of-hearing and deaf children in the nationwide network of Handicapped Children's Early Education Programs, funded by the Bureau of Education for the Handicapped of the U.S. Office of Education. We deliberately selected these individuals because of their long-term commitment and experience with establishing and maintaining parent programs. After three days of meeting, the group was able to agree on the major components of parent programs; moreover, there evolved a belief that these components were applicable to almost all child development programs for young children.

Several members of this initial group selected a specific strategy to pursue and agreed to provide a paper on the topic for review and critique which took place in a second meeting in May, 1972. The results of these activities are contained in this booklet.

The materials presented here should provide the reader with an extended overview of the dimensions of parent programs. It is hoped that it will be found useful to new projects and centers as they plan and develop comprehensive programs for parents.

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University of North Carolina, Chapel Hill
FALL 1972

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Norbert B. Enzer

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Chapter I

The Child Development Triad:

AN OVERVIEW of PARENT-CHILD and PROFESSIONAL INTERACTION

For those involved in programs for children, the primary goal must be to assist the young in any and all ways possible and appropriate. While for some that may mean almost exclusive commitment to direct personal work with the child himself, for others more indirect means may be more effective and efficient. For these people work with parents can be a most productive avenue.

During the past couple of decades there has been a growing awareness that the truism that "children need parents" conveys something very basic. Parent education is not new. Kessler (1966) has briefly outlined the history of the educational efforts for parents dating back to the early 1800s in this country. (1) However, far too many people have given only lip service to the notion that families, family stability, and economic and emotional security within a family were critical to a child's healthy development. Parents, and occasionally others in the family, must be brought into interaction with those in programs for children. Whether we address ourselves to day care for the very young, early education, or interventional programs for children with special needs, parental involvement can complement the direct efforts with the child. If a program has real goals for progressive development or change rather than simply time-filling activity for both child and staff, those responsible have the obligation of clarifying those goals to parents and gaining their assent. Then they have the opportunity of enlisting the parents as invaluable allies.

By custom and law, the young child in our society is always entrusted to adults for care. For the most part, those held most directly responsible for the health and welfare of children are natural, or adoptive parents or parent surrogates. These adults serve a variety of implicit and explicit functions. Most of what is expected of these adults is not in the legislation or the regulations of public child care agencies. It is often these more implicit functions and the individual attitudes of parents which are most critical to the positive growth and development of the young child. It is most unlikely that the young child will value that which is clearly of little importance to his parents. Overtly and covertly, obviously or subtly, deliberately or unconsciously, parents do influence a child's activities, interest, and his willingness to participate. In 1931, Pearson

concluded that "parental attitudes exert a more important influence on the formation of the child's personality than the actual events." (Pearson, 1931) Freeberg and Payne quote a number of studies indicating the importance of parental attitudes on their child's intellectual achievement and motivation. (Freeberg and Payne, 1967) The parent who, by word and deed, expresses an investment in learning and a genuine and benevolent interest in his child's acquisition of skill and knowledge, is likely to see joy and achievement in school. On the other hand, those few parents who, for whatever reason, convey a distrust of the school and its teachers, a disrespect or a disinterest in education, the attitude of "look at me and I never finished grade school," or, "it's not what you know but who," often find a similar disinterest in their children whose academic performance is frequently marginal. In point of fact, it is virtually essential that there be a commonality of goals between a child's family and those who work with a child outside his family. One aim of work with parents is clearly to insure that there is agreement about goals. This may seem an obvious point, but what is said aloud may not be what is meant. Those who work with children are all familiar with the situation in which a young child's progress toward independence and self-assurance is hindered or stifled by a parent's overly fearful concern for safety. Though parents in such situations may well express a desire for autonomy in their child, their behavior and their attitudes are influenced by other factors. Such a situation often arises when there is unconscious hostility toward the child dating to very early infancy or even to prenatal life. Such hostility and the resulting feelings of guilt are the consequence. With these feelings kept out of conscious awareness, the parent often attempts to compensate by overtly being a superlative parent. He tries to keep the child close and doing (rather, overdoing) for the child to compensate for the hostility and guilt. In this way the parent presents a public image of a "good parent." But from the child's view, such interaction of emotions and behavior creates smothering mothers and appeasing fathers. Though this is not an uncommon pattern, it is a particularly frequent occurrence in the families of children with handicapping conditions. Feelings of rejection may be compounded by disappointment, and guilt may be magnified by a sense that the parents themselves are responsible in some way for the handicap or defect. This psychological phenomena demonstrates that the parents who may agree consciously and verbally that a goal is appropriate may deep down reject it in part because the opposite situation satisfies some of the parents' needs. Parents' internal needs and feelings can interfere with progress and can actually undermine therapeutic programs even though they express agreement and consent.

Where there are special problems it is almost impossible for parents to have clear and realistic goals without a thorough understanding of the child's status. In a study Solomons and Menolascino (1968) point out how frequently parents seem to feel ill-informed about evaluations and state "the time, expense and effort involved in the evaluation of a mentally retarded individual can be largely wasted if the explanation to the parents is either inadequate or not understood." While emotional factors in the parents can interfere with the perception of an explanation, so too can an inadequate description of aspects of the program lead to further troublesome feelings.

Establishing a Productive Relationship with Parents

It is essential that a true alliance be created with the parents. Fundamental to such a relationship is mutual respect, honesty, and an egalitarian attitude on the part of worker and parents. While occasionally parents do present themselves with these assets, it is more likely that the climate will have to be created.

No one can produce such an atmosphere unless he or she is willing from the outset to be nonjudgmental of parents, to understand that there are needs and feelings of which the parents themselves may be unaware and that, though parents may have little formal knowledge of child development or of parenting, they have a great deal to offer and all can learn. Parents may approach a helping situation with widely differing attitudes. They may believe that they have little to contribute and are helpless. They may look to "experts" for direction and full responsibility, or, at the other end of the spectrum, they may view all helpers with suspicion and anger. Parents who present themselves as inadequate may be truly seeking advice and guidance or they may be testing the resourcefulness of the helper. Focusing on some particularly appropriate interaction with their child and commenting "you seemed to sense his needs very well", or "you seem to be saying that he enjoys it when you do that and you sound as if you do too", or simply "that sounds good" may be very supportive and helpful.

When parents are hostile or skeptical, it is important to bring these feelings into the open rather than attempt to placate them. Often parents of children with chronic illness or handicaps have been frustrated and disappointed by others. If the professional recognizes this feeling by saying something like "that must have been disappointing" when the parents recall their anger about the lack of help elsewhere, it may help parents relate their feelings. This gesture conveys to them that the helper is willing to listen to the frustrations of the past. Allowing parents to give a complete history in their own way and at their own pace, and giving them specific opportunity to present some of their child's assets will help to convince the parents that the worker is really interested in their opinions, ideas, and observations. All parents have concerns and problems with their children, but this is especially true of parents of children with some handicap or chronic disturbance. One must never take concerns lightly. They are always serious to parents or they probably would not be mentioned, though there may be even more important worries that the parents will convey once they have assured themselves the helper will listen. It is not an uncommon occurrence for a mother and child to be in the family physician's office for a school check-up or some minor complaint and at the end of the examination the mother says in an offhand manner, "Oh, by the way, Doctor, Suzie has been very sassy lately." In many cases, it is quite apparent that the *real* reason for the visit was not the initial complaint about a minor physical symptom but rather a concern the mother was hesitant to present at first. In the illustration, if the physician brushed aside the mother's initial complaint or did not seem to listen to her, the second more important concern might not have emerged. Saying "I would not worry about that" is rarely helpful. "I can see you are concerned" or, "you must have been very worried" is much more likely to offer parents encouragement to say more. Furthermore, judgments about the seriousness of parental concerns are never justified until there is a good deal of information available upon which to make such a judgment. So much depends on the quality of the initial contact with the parents that it is frequently most helpful to use the initial visit simply to "set the stage" attitudinally.

For example, a psychiatric consultation was requested for a young boy hospitalized to investigate rather long-standing, but vague, complaints. Nothing had been found in initial studies and it was considered likely that the symptoms resulted from emotional or interpersonal conflicts. The psychiatrist found the mother resentful that such a possibility was considered. She believed it somehow implied there was "nothing physically wrong" and that she was at fault for the problem. The consultant elected to listen to these feelings and to the mother's very great concern and fears during his first visit. Following this, the mother related more positively and offered a detailed

history which had not previously been obtained that provided the basis for specific tests, the results of which did establish a diagnosis of an early form of a serious but treatable chronic illness.

Janis Jelinek in Chapter III of this publication discusses the matter of information exchange. However, in addition to the exchange of information, the above example does show the importance of the interpersonal relationship between parent and helper. In the case above, the mother provided historical information about her son's illness to the psychiatrist that she had not offered to others. She said that others were too busy to ask for details. She further indicated that she was often so upset in previous interviews with others that she would become "mixed-up" or forget things. Reliable information exchange requires a relationship of mutual trust and respect. Parents are not likely to offer maximum information without a solid relationship and they are certainly not likely to accept professional opinions or suggestions unless they trust the person making the suggestions. All too many professionals hide behind their degrees and pontificate wisdom to parents without the slightest recognition of the interpersonal factors. This unfortunate situation, along with the nature of the information and the language, often accounts for the fact that so many families seem confused and disappointed, and so many do not follow the advice that was given. People do not listen well if they are upset by a situation. It is often remarkable how much can be accomplished by patient, thoughtful and empathic efforts to improve the communication pattern between parents and helpers. Matheny and Vernick demonstrate in a study the effectiveness of efforts at effective communications regarding the evaluation of retarded children. (Matheny and Vernick, 1963) In their study, they promised to discuss "everything" with parents, encouraged parents to participate in the evaluation and to ask questions. Further, it was suggested to the parents that they should not hesitate to put pressure on the staff to communicate and if there were difficulties or further questions a particular staff person was available to help manage or interpret communication problems. Though relatively little time was devoted to these efforts, most parents did show significant positive change in their expectations for and behavior with their retarded child.

It is of utmost importance in the creation of an alliance with parents that they believe those offering help can in fact be helpful. The definition of the nature and the extent of the assistance has both specific and nonspecific aspects. The nonspecific component often deals with the emotional factors of the parents themselves and their relationship with the individuals involved with themselves and their child. Drs. Schlesinger and Meadows in Chapter II of this publication deal in more detail with some of these matters in their contribution dealing with emotional support. They indicate that one of the more frequent reasons why parents view certain programs negatively and why, particularly with a handicapped child, they "shop"—go from program to program, agency to agency, professional to professional—is that there is little recognition of the emotional stresses and the needs within the parents themselves.

The Importance of Honesty and Timing in Outlining a Program

The more specific aspects of help involve the direct work with the child and the definable alternatives, new perspectives, or techniques which parents themselves might develop with help. A careful description of the nature and the extent of the services available must occur early in any contact with parents. It may appropriately follow the establishment of an early relationship and after the parents have provided some information regarding their child. By this time the worker should have at least a pri-

mary notion of the child's needs and the relevance of the available services. Early definition can avoid a great deal of later difficulty.

In one case parents of a young child with cerebral palsy were very angry and disappointed when, after devoting time and money to an evaluation for admission to an educational program, they learned that they themselves would have to do most of the work at home under the direction of personnel from the program. These parents had wanted and expected a day nursery school program because, among other things, the couple felt the necessity of the mother's returning to work to assist in paying the many family debts. Early delineation of the nature of the services, the limits of services and the obligations of the program staff and of the parents, as well as the costs, is assurance that, in fact, people have come to the right place. If they have not, they should know that early and be offered assistance in locating services more appropriate to their needs.

The basic foundation of parent work in a child development program is the creation of an alliance with concurrent goals, mutual respect and a recognition that both parents and program personnel each contribute uniquely to the progress of the child. In some cases, it is critical for parents not only to give true permission for the child to be involved and to avoid undermining the attempts of others to provide help, but also to be more involved in the interventional efforts or to assist in other ways. Both Drs. Simmons in Chapter IV and Northcott in Chapter V deal with certain dimensions of this matter. In this regard several issues are critical. First, the interactions between parent and child must be as productive and adaptive as possible. Parents must be encouraged to provide an emotionally warm, secure relationship with their child and to support and reinforce progress and positive behavior. Very often when parents recognize the existence of problems there is a tendency to focus on those concerns and to ignore the more positive aspects of the child's functioning and his behavior or to minimize other important aspects of his life. For instance, when parents note that the child is having difficulty in accepting appropriate limits or discipline, they may feel the youngster is not developing an adequate respect for authority, and may become apprehensive about all kinds of serious consequences during adolescence and later life. They may not notice the times when the child's behavior is quite appropriate or they may not respond to that behavior. To the contrary, they may be constantly on guard for misbehavior and may even set up artificial situations in which they attempt to exert authority. In one such case, a mother decided that her little first grade daughter should wear certain clothes to school each day and that she respect her mother's wishes and authority in this matter. The effect of this was that each morning there was a lengthy, angry, often tearful interaction between mother and daughter, at times ending with the mother's acquiescing to prevent tardiness. Though this interaction was totally negative in content, the daughter did get her mother's undivided attention during this period of time. When this was discussed with the mother, she recognized that the issue of dress was really quite trivial but that she was so concerned about what she viewed as the beginning of a serious behavior disorder that she felt she had to "pick up" on any and all rejection of her authority. She easily could give numerous examples of problems, some of which were of greater consequence, but she and the father both had trouble recounting specific examples of positive behavior, though both admitted that she was not "bad all the time." They did come to recognize that they, in fact, were ignoring her more appropriate behavior and were instead responding primarily to the inappropriate. They really were missing the joy and satisfactions in their daughter's achievements and she, on the other hand, was performing in a way that brought a predictable, but negative, response. In a sense, the little girl was substituting parental attention (negative attention) for parental approval which was much less pre-

dictable. Social interaction, even negative interaction with people who are important in our lives, can be reinforcing, and it is often better to be scolded than to be ignored. On both sides there was anger and disappointment. The parents felt the little girl was deliberately trying to antagonize and she felt unloved and unappreciated. In this case, much was accomplished as the parents began to interact with her around appropriate and desirable behavior, to ignore the trivial, and to discipline with a minimum of interaction by *brief* separation. Perhaps equally significant was the profound change in the emotional relationship and the pleasure the parents experienced in their daughter's success, and she in turn began to feel increased self-esteem.

Of great moment is the value for parents, and for others involved with children, of a clear recognition of assets. Above, it was mentioned that to neglect or to make light of parental concerns has the effect of undermining a relationship between helper and parents. While initially parents with concerns about their child often want to address themselves to problems, it is equally important to gather information about the child's strengths, interests and his play. These assets may be used to build upon in trying to aid the child. Knowledge about these aspects of a child's life can be used by teachers, therapists and others to motivate, to capture positive interest, and to aid in establishing rapport with a child. Furthermore, such attention conveys to the parents an interest in the totality of the child's life and not just in some dimension of pathology or deviance. Frequently parents who come asking for help have been caught up in the problems and have been so worried and anxious about their child that their own view is distorted. They need to develop some balance in their assessment of the situation. Parents of handicapped children or disturbed children often need help in seeing the joy and satisfaction of being parents. There is a further, almost paradoxical value to inquiring about assets. When talking about assets, the parents' previous attempts at denying certain aspects of the problem seems very much more obvious; and often it is helpful to the parents in recognizing that they have been trying to hide things from themselves.

Communication Between Parent and Child

Communication between parents and children is frequently disturbed. In the presence of developmental disturbances in the child, this can often produce serious compounding of interactional and emotional issues synergistically. Attempting to interpret the immediate needs and the demands of a young child may be difficult enough for any parent, but when there are disturbances in perception—particularly auditory perception—or disturbances or delay in verbal communication and language, this may become critical. Additionally, the young child tends to interpret literally what is said to him. It may seem trite but it is worth noting that to the three-year-old, there really is quite a difference between being told "you are a bad boy" and hearing "it is bad to kick the cat." If there is a delay in cognitive development, the usual development of more symbolic language is delayed and the concrete, literal interpretation continues beyond that of most children. Related to the difficulty of the young child in appreciating symbolic communication is the matter of destructive or incendiary communication. When anger or frustration is expressed, it often tends to be personally denegrating. "You are a careless slob" is a comment that conveys disappointment and rage. It is attacking and abusive, and is likely to inflame. It offers little productive response. On the other hand, "it really gets my goat when you don't clean up your room" carries a clear explanation of the unacceptable act and focuses on the behavior, or lack of it, rather than on the person. It does provide sufficient clarity about the offense so that the other person has some idea of the expected response.

Questions also can pose problems in communication with young children and with those delayed in cognitive development. As adults we often find it more appropriate to request rather than command, and more often than not, adults recognize the difference between a true question and a rhetoric question for which compliance is expected. To say "will you please come to the table?" may be quite appropriate with adult guests at a dinner party and all will comply. A similar question to the young child may be answered with a, "no," for he may well view it as a question rather than a request for action. "Will you clean up your room?" may well be ignored, while "clean up your room" may produce a fairly prompt response. Parents can often gain considerable insight if, with the help of a parent worker, they attempt to figuratively place themselves in the child's place and try to imagine how he might react.

Behavior and Self Control

Control of behavior is often of great concern to parents and, as noted above, these concerns may interfere with other aspects of the parent-child relationship. In a great many cases what is forgotten is that human beings are not born with self control and that it develops only gradually over time and largely in a manner more or less concomitant with early cognitive development. For practical purposes in the first year of life there is no self control. After that, again gradually, controls begin to develop. Initially, the control of behavior is highly related to specific people, places and times. The little child may not touch his mother's favorite ash tray in the living room if she is present. But if she is not, he might. Furthermore, he may not generalize to other ash trays in other rooms. These primitive controls are largely related to the anticipation of some negative response from others or to past experience of pain or injury. It is not until about the time that the average child enters school that he develops an internal sense of something being "wrong." Often parental concern about mischievous or negative behavior results from a lack of appreciation that the young child has not developed a real capacity for self control. Too much is expected. However, another common issue is the lack of consistency. If mother reprimands him for touching the ash tray but father does not, the child is left confused about ash trays. He may "behave" in mother's presence but not learn to generalize.

Expanding the Role of Parents

Attempting to improve the quality of parent-child interaction may be very useful in extending interventional efforts. However, in some situations, particularly those where there are specific therapeutic or habilitative efforts for disabilities, it is essential that parents actually learn more about the nature of the disturbance and the specific techniques which are useful. This may well provide parents with skills by which they can directly continue certain of the procedures in the home. Care must be taken to help define the boundaries and limitations of this type of effort on the part of parents and they may need considerable direction. One pitfall is that parents may so focus on certain technical and highly specific procedures that they may ignore other aspects of the child's life and of their interaction with him. A similar word of caution can be expressed to all who work with exceptional children. Unfortunately many programs for children with learning disabilities, for instance, devote so much time and effort to the remediation and development of specific educational skills and forget that there is a need for general information acquisition as well. The child with dyslexia may not be able to acquire information from the printed page, but he often can through auditory means, and his need to know about the world and its people is no less than the child who reads well. In regard to parents particularly, the role as teacher or

therapist may complicate the role as parent. It is critical that both parents and program personnel continue to recognize the primacy of the parental role and its essential place in the child's development. Parents can work with their children but they must continue to be parents.

The Whole Family: A Need for Balance

Another corollary aim of parent work is the attempt to strengthen or stabilize the more global family situation. It is generally accepted that the home in which there is emotional warmth, mutual respect, encouragement, the opportunity for communication, honesty, consistency and security is a more optimal setting for the child's development. Achievement of such a home may be beneficial for any child and some parents may need help in working toward that goal.

The family with a handicapped, deviant, or chronically ill child has special problems and the stage is set for unique pitfalls. Pediatricians are all too familiar with families of children with serious chronic or life-threatening illnesses. The devotion of economic resources, emotional and physical energy, as well as time itself, to one member of the family may produce a situation in which others suffer needlessly. Such a danger exists even when parents are truly involved in trying to aid any child in a family with a problem. All of us have seen the mother of a retarded child devote so much to that child that she offers little to the others in the family.

There is no denying that children with special problems need special help. However, it is essential that those involved with these families recognize the need for balance, and that they constantly remind themselves and the parents that others have needs as well and that there are limits. All too often, an exceptional child is a seed which, if nourished inappropriately, can become a destructive weed within the family. The guilt, anger, and disappointment within the parents can be magnified and displaced. The devotion to the one child can be rationalized on the basis of the child's needs and the feelings and needs of others denied. It would seem that even the most skillful therapist might have great difficulty in managing some situations. However, in many, that is not the case and families can be aided in avoiding such tragic results which naturally impede the progress of the child whose problem seemed to be the axis about which all of this disruption occurred.

The therapeutic alliance with the parents does offer a foundation for strengthening a family. Some have found that with appropriate direction and assistance, often nothing more than a sounding board for family emotions, families can become closer and stronger. It is worth mentioning, in passing, that certain cases do arise in which stability may only occur with separation or divorce of parents. If the parents believe they cannot continue to live together in harmony and are only staying together because of the guilt or other feelings resulting from the presence of a handicapped child, the reality of these feelings must be explored. It is often more difficult for parents to recognize their own feelings and needs in the presence of a child with problems and it is particularly difficult for some parents to separate themselves from an intolerable union if it would appear to others that they were deserting a handicapped child.

Parent as Volunteer Worker

A final corollary goal is that of enlisting the aid of parents in various aspects of programmatic work and/or support. We have seen abundant examples of the effectiveness of parents in aiding the creation of child development programs, supporting and sustaining programs, in providing public information and in creating public interest. Dr. Northcott in Chapter V addresses herself specifically to some of these points.

Preparation for Progress

There are times when, because of the severe nature of a child's problem or because of disruptive, noxious influence within the home, it is appropriate for a child to be removed partially or totally, at least for a time, from his family. These situations provide good examples of another aspect of family work which has implications in less dramatic cases. Children can change, and even the most handicapped may progress. Parents and families may need considerable help in adapting to change. The changes that occur in a child require newer or alternative behavioral responses on the part of parents. While this is true with remediation of all handicaps, it is quite striking if a child has been out of the home. One little retarded boy was sent to a special residential school at about age seven. For all practical purposes, he had no self-help skills and the family seemed quite overwhelmed by this and other problems. While he was away, help was offered to the family but they refused it. At the end of a nine-month stay at the school, he was returned home, now quite able to dress himself and feed himself. He was much more facile in making his needs known. The initial response of the family was to see him as demanding, stubborn, and selfish. The mother continued to try to dress and feed the child for she could not believe he could do either correctly. Within a few months, gains had largely been lost and there was, in addition, punitive parental behavior over what they saw as a behavior disturbance. The original equilibrium which, though troublesome to the parents and not conducive to change in the child, had been altered, and no preparation had been made for the reentry of the child into the family and for adaptation to the progress he had made.

Clearly children have needs for parents. Children have basic biological needs which are usually the responsibility of parents, but they need much more. Every child needs emotional warmth and security, a feeling that others respect and value him, a recognition that those adults most important to him appreciate his achievement and his accomplishments. He needs a sense of belonging and a responsive focus for his own emotions, benevolent controls, discipline and a concern for his safety, and he needs role models. Parents have needs too—needs for their children. They need to feel the responsive warmth of love in return for their attention to the child. Few parents seem as sad as those of the unresponsive infant who doesn't seem to care about the presence or absence of parental attention. They also need to feel that they are "good parents" and that their child is progressing toward the goal of health and happiness. They need to feel a sense of pride in their child. For some parents, the emotional investment in their child is clearly excessive and pathologic. They may have standards of expectations beyond the child's capacities, or they may want to live vicariously through the child. It is these parents who are most vulnerable to the impact of a handicapped child. The feelings of guilt, anger, rejection, disappointment, and stigma which are present to some degree in all parents of the developmentally disabled child can have particular impact on those parents who tend to invest excessively in their children. In all cases, it is part of the task of the parent worker to aid in bringing about a balance between the child's needs for his parents, the parents' needs for their child, those needs of the parent partners for each other, and the needs of others in the family.

There is a similar mutuality of need between the child development program and the parents. Both are concerned with the optimal development of the child in all spheres—physical, emotional, intellectual, social, and interpersonal. Both aim at the child's reaching the highest possible level of adaptation. The program needs the parents' cooperation and assistance in a variety of ways, as will be documented in subsequent chapters. The parents need support, advice, direction and information from program per-

sonnel. None of this can be accomplished, and the child's progress will suffer unless there is a close, compatible, working relationship between the program and its staff and the family.

The presence of a handicapped or exceptional child places very special stress on the integrity of a family and on the individual members of a family. Though specifically concerned with parents of a mentally retarded child, the Group for the Advancement of Psychiatry outlined some factors applicable to other handicapping conditions. "The physician is dealing with parents who have a multifaceted problem: I. They may not have fully accepted the diagnosis of mental retardation. II. They have varying degrees of guilt feelings about their possible role and about the causation of the child's condition. III. They resent the fact that this has happened to them and tend to try to find some outside influence on which they can blame the problem. IV. They hope for a magical solution. V. They have come seeking advice. "Each of these factors deserves separate consideration by the physician who must realize that he himself will have certain reactions to the child's condition and to the parents and their emotional problems." (Matheny & Vernick, 1963) While these comments hold true for conditions other than mental retardation, so too do they hold for helpers other than physicians. These emotional responses, along with the economic and social pressures that are related to the special child, usually require special efforts with the parents, as well as with the child. Aside from the general needs of parents, these families may deserve assistance in understanding the disability, the nature of the intervention and their role in it, and particularly in creating expectations which are consistent with the prognosis. Honesty is essential but it must be conveyed with empathy and understanding. Many parents have had experiences with a "hit and run" approach by professionals. They have been given a diagnosis—unfortunately in a manner that borders on the thoughtless—without any attempt to offer assistance. One of the most reassuring actions can be the promise to continue to work with the family and the child to find the best possible resources. The offer to "stand by" and to continue to be available does help prevent the feeling of loneliness and desperation so frequent in parents of handicapped children. Parents may also need assistance in dealing with the variety of professionals who may be involved with their child, i.e., where to go, what to ask, and what to expect.

The necessity of parental involvement in child development programs raises the question of who is to work with the parents. For some time, it was the practice that those who worked with families should have little contact with the parents. Where there are particular circumstances when that seems appropriate, it is neither always necessary nor possible. It would be ideal, if all programs could have available highly skilled family workers. The absence of such staff, either because they are simply unavailable or because there are not sufficient funds to support them in adequate numbers to meet the needs, does not reduce the necessity for a working relationship with the family. In later chapters specific approaches to such work are outlined which can be utilized, depending on available personnel and time. There are limitations however. Very often the hesitancy of a staff to invest in parent work is related to a feeling of inadequacy. Even in the absence of trained workers, funds can at times be found for consultation which can enhance the skills of others. The fact of the matter is that teachers, child care workers, physical therapists and many others are forced into these activities by necessity. Though lacking specific training, these people can be tremendously helpful. Their interest, patience and willingness to listen can be remarkably supportive. An empathic response to the emotional stress of parenthood does not necessarily require extensive training.

In what way can one work with parents? In general, the work can be primarily directed to a sole

parent or couple, or they may be involved with others in group work. Certain parents may have particular needs or desires which may make an individual or group approach more appropriate to them. Some parents feel more comfortable in a group and feel they get additional help from other group members. On the other hand, a particular parent may be quite disruptive in a group and might better be seen alone. Regardless of whether a group or individual approach is used, certain basic patterns exist, and it is of value to be clear about the intent of the work. The patterns and methods will vary depending upon the type of work to be accomplished. Psychotherapy can be thought of as a process in which there is an intense, often quite dependent relationship of a patient to his therapist. Regression and introspection are encouraged and often anxiety is created before major changes in function begin. In general, there is a non-authoritarian approach on the part of the therapist. Counseling can be thought of as a form of supportive therapy in which the relationship between client and counselor is less intense and in which regression is avoided. More effort is likely to be directed to real current-day problems and feelings than to internal conflict and past experiences. Guidance is a technique directed specifically at aiding a client in finding ways to set and achieve goals and to avoid conflict or troublesome situations. This type of work depends upon an authoritarian relationship. Education is a means by which an individual develops new knowledge and abilities to solve problems by careful analysis of a situation. Though education usually involves a teacher and a student, that is not always necessary. However, the goals and the end points of a truly educational effort are mutually set and the pathway not necessarily predetermined. Training is another approach. Unlike education, training implies the development of specific predetermined techniques. Flexibility in problem-solving or the ability to apply basic principles broadly are not necessary components of training. Any or all these various patterns can be useful with parents of handicapped children. They may be used in groups or with individuals, but it is important that both worker and parent know what is being done and agree on the goals.

The reader of this manual will note considerable overlap between the various chapters. While the authors have attempted to direct their attention to specific issues regarding the relationship of parents to programs for their children, several themes are common. Trust and respect are basic to all work. Interpersonal relationship depends on several real factors such as feelings, many of which are beyond awareness and expectations, some of which are based on hopeful fantasies, and upon past experiences. Openness, honesty, and an appreciation for one's feelings and one's concerns are essential. A large measure of the success of a child development program rests upon the triad of program personnel, parent, and child all working toward the same ultimate goal. Our hope in working with parents of handicapped children is that we can assist them through the emotional disorganization that accompanies the recognition of the exceptionality of their child. Our hope with all parents is that we can aid in developing a mature, flexible, though concerned, adaptation to their children.

BIBLIOGRAPHY

Freeberg, N.E., and Payne, D.T., Parental influence on cognitive development in early childhood: A review. *Child Development*, 1967, 38(1), 65-87.

Kessler, J.W., *Psychopathology of childhood.* New Jersey, Prentice-Hall, Inc., 1966, pp. 410-455.

Matheny, and Vernick, Mental retardation: A family crisis—the therapeutic role of the physician. Group for the Advancement of Psychiatry Report No. 56, 1963.

Pearson, G.H.J., Some early factors in the formation of personality, *American Journal of Orthopsychiatry*, 1931, I, 284-291.

Solomons, G., and Menolascino, F.J., Medical counseling of parents of the retarded, *Clinical Pediatrics*, 1968, 7(1), pp. 11-16.

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Chapter 11

Emotional Support to Parents:

HOW, WHEN, and by WHOM

A teacher involved with preschool programs will soon note that the primary task of imparting new skills to children can be more effective by constructively involving the parents of her young charges. Early childhood development programs have clearly shown that parental involvement is necessary for optimal progress. Such parental involvement is even more crucial for the development of children with a handicap. Recently, most preschool programs have provided a program for parental involvement and participation. This chapter will describe the helping process: how the need for help develops and in what areas, and by whom it can be given at what time.

The Need for Help

As each child grows to adulthood, he develops his own specific, relatively unique, and consistent ways of dealing with self and other people and objects. The choice of ways is probably determined by a complex interplay of inborn characteristics (such as the genetic components of intelligence, and constitutional aspects of temperament) and social relationships originally and primarily with parents.

Each individual thus functions in his or her own setting with certain consistent patterns and with minimal self-awareness and sense of strain. Although constantly faced with situations calling for problem-solving, availability of habitual ways and patterns permits a solution with relative dispatch. This is not to say that ways of relating to objects, activities or people remain static throughout life, but that there is an underlying theme that appears to remain constant. For example, some infants show pleasure at the relatively

rapid introduction of new stimuli whereas others require a more prolonged period of introduction.

There are, however, many important developmental tasks that are so novel or important or so difficult that the usual and available problem-solving mechanisms either do not apply or are not sufficiently complex. Then the individual is unable to accomplish the developmental task because of a psychological block.

When human beings cannot solve a problem, anxiety may develop and a minor problem can become a major crisis. New coping mechanisms can be found by elaborating on the previous ones; trial and error may bring good results. A crisis left too long unresolved can precipitate avoidance of a problem or distortion of a problem, or a breakdown in the individual's usual equilibrium.

Most of us do not face a crisis alone. Fortunately, we have the help of family, friends, neighborhood, community and even nation (Caplan, 1964: 43). An individual in crisis, in disequilibrium, which affects his usual activities and interpersonal relationships can benefit if another human being can assume temporarily the function of the "helper" and provide emotional support. According to Ross (1964: 75) the personal qualifications of such a helper are more easily listed than acquired. "They include the human qualities of acceptance, understanding and warmth; the professional attributes of objectivity, confidence and knowledge, as well as the technical skill of listening and talking to people under stress." It is not easy to arrive at a definition of emotional support. In the present context it might be "that help given to a person in crisis that is designed to restore him to his previous adaptive equilibrium." In addition, we can hope that this emotional support will enable the individual to seek and to find new adaptive mechanisms and to go beyond his old equilibrium in adjusting to the new situation. The ingredients of emotional support include the provision of an opportunity to discuss the problem; the opportunity to meet a helping person who can listen patiently, non-anxiously, and non-judgmentally, and who can respond with warmth, honesty, and interest. This person can provide knowledge about the crisis effectively and authoritatively and he can admit ignorance or lack of knowledge confidently and without strain. A helping relationship is most effective when the two participants can meet as equal human beings only one of whom temporarily needs help. Assumption of superiority on the part of the professional inhibits growth and may produce dependency rather than foster creative self-growth.

The Parents Needing Help

The birth of a normal child into a family is in itself a potential life crisis. The life style of the family members is almost always drastically changed and a readjustment of roles within the family must be achieved. The ability of each family to welcome the arrival of a small, entirely dependent human being depends on the maturity of the parents, their sense of self-esteem as persons and spouses, and their willingness and ability to receive a child of a particular sex and a particular temperament at this specific moment in their lives. The child-to-be is usually seen as an idealized human being who will be able to meet or surpass his parents' achievement and is seen as generally giving pleasure. Nevertheless, from early pregnancy onward the same idealized child may well frustrate some parental needs, evoking resentment on occasion.

The expected idealized child can be seen as a gift to the mother herself, to her husband, or to her parents. If the child is not perfect, latent conflicts are revived even in the most adjusted of parents. During the process of suspecting, recognizing, and identifying the handicap, it would appear that the following emotions are common among parents: shock, bewilderment, sorrow, guilt, and anxiety. Anxiety is a frequent spectre and "tugs" at parental self-esteem and effectiveness prior to the diagnosis, at the time of the

diagnosis, and for many months thereafter. The impact of rubella in the early months of pregnancy, the knowledge of Rh incompatibility or of an infectious illness intensifies the usual parental anxieties about the normalcy of their newborn. Anxiety is an unpleasant emotion characterized by such physiological changes as increased heart rate, breathing, sweating and trembling. This early anxiety is frequently accompanied by parental suspicion that something is amiss with the child and, indeed, parents often reveal themselves to be excellent diagnosticians. Bewilderment and shock occur because of the discrepancy of the expectations and the reality. Sorrow, frequently chronic, may be accompanied by a genuine mourning reaction for the loss of the expected perfect child (Ross 1964). Guilt feelings, almost always irrational in nature, occur frequently. The parents may ask themselves "Why did this happen to me?" only to come up with the answer "Because I was bad." Parents often search within themselves for a reason for the defect, a reason which they feel should have been preventable. Such a self-dialogue awakens feelings of resentment and anger directed at the self and at the child. However, negative feelings about a child are unacceptable to most parents and are translated into feelings of guilt.

Parents of any newborn child are faced with a new set of circumstances because the baby has physical and emotional needs. Most new parents have learned something about babyhood and can find ways of coping and satisfying their infant's needs. With a normal infant, growth and development are seen as something predictable, certain, and acceptable, the end result of which is to become an adult much like themselves. Parents of a child with a defect do not usually have the same opportunity or certainty. These parents want up-to-date and accurate scientific information about the child's condition. They want to know how and when it affects the normal course of child development. Furthermore, these parents want to know what they can do to help their child develop to his capacity and what they may expect this capacity to be. Feelings must be dealt with and ignorance replaced by knowledge.

Many parents cope with the birth of an exceptional child in healthy constructive fashions with a minimum of professional help. They have learned from other crises in their lives how to live with feelings, to tap inner strengths alone, or to accept support from relatives and friends. They have also learned to acquire knowledge—books, articles, and movies are used successfully. Other parents, however, need professional support both in the area of acquiring knowledge and for emotional support. In this, a teacher can be of paramount importance to child and parents. She can be the provider of information and emotional support.

The Teacher as the Helping Person

Optimally, educational intervention will occur early in the life span of the exceptional child and the teacher will meet the parents shortly after the disclosure of the diagnosis. The perspective of the meeting ground may differ for teacher and parent. The teacher may be ready and eager to initiate educational techniques, whereas the parent may still be dealing with the impact of the diagnosis or the contact with the experts. The diagnosis of an early childhood defect is a doubly traumatic event both to the parents who are reluctant to hear it and to the professionals who are reluctant to speak of it.

Ineffectual professional stances have resulted from this reluctance. The professional may choose to use a hit-and-run technique of providing the threatening information, leaving the parent laden with feelings but with no one to help. Alternatively, the professional may attempt to deal with parental anxieties by minimizing the problem or by giving false hopes; many parents wear rose-colored glasses that were given to them by professionals.

Another ineffective professional ploy is to

retire behind a mask of objectivity. However, Beck (1959) and Meadow (1968) have pointed out that parents are more likely to listen and to integrate painful and unpleasant information from interested and "feeling" individuals. A professional who leaves the scene or does most of the talking but does not *listen* is an ineffectual helper.

The most helpful of all supportive roles is the listening one. Before providing necessary information, the teacher will need to provide a listening post for the parent; he should be a sensitive human being who is able to listen to the parents non-anxiously, sympathetically, and non-judgmentally.

The ability to listen to the expression of feelings in non-judgmental and accepting ways presupposes a knowledge that feelings are always acceptable, but that the behavior which springs from them may be undesirable or detrimental to parent and child. Such careful discrimination between feelings and deeds is helpful to parent and teacher. Most parents will experience immense relief at the opportunity to have someone listen before they can proceed with the process of acquiring helpful information.

A few parents, however, because of prior emotional disturbance or lack of other support will be overwhelmed by their feelings. These parents do not obtain relief from ventilation of their feelings and indeed appear overwhelmed. Frequently, these parents provoke anxiety in the teacher (a signal that the teacher herself needs some help). This can be obtained from a more experienced teacher. Hopefully, the teacher will also have access to a mental health professional (psychiatrist, psychologist, social worker) who can serve as a consultant to the teacher. Some parents will need more intensive support and may need to be referred for counseling and therapy. The listening teacher who is helpful, however, can give adequate emotional support to most parents.

Let us reiterate some of the important qualifications of a helpful person: acceptance, warmth, understanding, genuineness, objectivity, confidence and knowledge as well as the ability to listen and talk with people under stress.

We have described above the helpful listening stance. There are some equally important ingredients of the helpful "talking" stance. Knowledge about the exceptional condition, ability to convey knowledge authoritatively and with confidence but without superiority or authoritarianism are important. Of paramount importance is honesty in two opposite areas: knowledge and ignorance. Hopefully, the teacher will be able to state clearly and comfortably what she does know about the exceptional condition of the child and equally comfortably what she does not know.

Emotional Support in Dealing with Feelings

We have previously indicated the myriad feelings evoked by the birth or diagnosis of an exceptional child. How do parents deal with these feelings? Ideally they will find an opportunity to share the feelings with a supportive person, spouse, parent, friend, or professional, and after a necessary period of mourning, proceed in a rational way to help the child grow to his highest and most realistic potential. However, human beings—at least in today's society—are subjected to pressures to behave and feel in an unrealistic fashion. In our early days when something hurts we are told "don't cry, you are not a baby." When events seem tragic we are told "everything will be O.K., buck up." A vigorous but unsuccessful attempt is made to banish all uncomfortable feelings. This banishment sometimes occurs by denial—"the tragic event did not happen"—or by repression—a banishing from consciousness of feelings or impulses which seem unacceptable. However, the understandable attempt to reduce, translate, or eliminate uncomfortable feelings is not particularly effective. Indeed the attempt often backfires, and the feelings explode with greater intensity.

Sometimes anger springs forth in irrational accusations that the spouse or the doctor is responsi-

ble for the child's difficulty. At other times the anger with the child is translated into overly rigid adherence to therapeutic regimens, ostensibly for the child's own good but with a fervor that seems almost punitive. Occasionally, the anger with the child results in parental vacillations between overprotection and overt rejection. Another possible pathway for parental reaction appears to be self-sacrifice and martyrdom for the child's sake. These reactions performed unconsciously to be sure, are not optimal solutions to the diagnostic crisis. Although it is not the task of the teacher to delve into the intricacies of the parent's basic personality or into his unconscious processes (Ross, 1964: 79), the existence of such processes within all of us needs to be kept in mind. Some basic understanding of the unconscious nature of much of human motivation can be of great benefit to the teacher listening and talking to the parent. Behavior mediated by conscious motivation is purposeful and intentional in nature.

A stranger who consciously ignores a handicapping condition does so purposefully, allegedly to protect parent and child. A parent who overlooks the same problem in his own child does so unconsciously to protect himself against anxiety. Such behavior by the stranger or parent may provoke the teacher to anger. A simple explanation that "being overlooked because of the problem is worse than being accepted with the handicap" may be sufficient to effect a change of behavior in the stranger. In the case of parents no amount of exhortation to "see reality" will be effective. Although the teacher should not share the denial with the parent, she needs to recognize that the parent may temporarily need the denial in order to obtain protection from overwhelming anxiety. If the teacher can appreciate that the parent does not intentionally choose to refuse to see the defect, does not get angry at the professionals on purpose, she will be less likley to condemn or exhort to reality, and be more able to listen non-judgmentally.

Some parents frequently astonish teachers (and other professionals) for they say they want advice and then do not follow it; they say one thing in words and another in behavior. Such a disparity between thinking and behavior also has unconscious motivation and is not easily resolved. However, an understanding of the discrepancy usually enables the teacher to react with equanimity rather than with puzzlement and anger at the contradictory behavior.

In general the teacher will be most effective by genuinely accepting the parent's feelings. We stress genuineness, for lip service to acceptance would be ineffective. All of us have learned to understand the non-verbal language, and although one may say "I accept what you say," one's true attitude comes through. Acceptance does not mean total approval of everything the parent says or does. It does mean that the teacher accepts the parent's feelings that underlie the "unhealthy" feelings or undesirable behavior and helps the parent deal with feelings in a constructive fashion.

Again, in summary, a sympathetic, nonjudgmental teacher can effectively help most parents in dealing with the feelings evoked by their children and the handicap. Some parents will need a more intensive form of counseling best offered by mental health professionals. Although it is not easy to clearly differentiate between the two groups in words, the teacher can use her own feelings as an indicator. If she is comfortable with her own feelings, she is probably being helpful. However, if her own discomfort is increasing, it is likely that a consultation with a more experienced mental health professional will be helpful and a decision to refer the parents elsewhere can be reached collaboratively. Some teachers do not have access to mental health consultants and must of necessity make the referral by themselves. Such referrals are always sensitive in nature and are more effective if the teacher is able to say, "I am sorry that I cannot be as helpful to you as I wish to be. I would suggest that . . . " She thus places the burden on herself, rather than implying a vast degree of emotional

disturbance in the parent.

Emotional Support in Following the Prescriptions and Proscriptions of Professionals

We have previously outlined the diagnostic crisis, the conflicts between parent and professional and the emotional support provided by the teacher in the resolution of this first crisis. The diagnostic crisis is frequently followed by a treatment crisis. For advice given at the time of initiation of treatment can result in a multitude of prescriptions and proscriptions that are or, are perceived to be overwhelming, or conflicting or incompatible. Furthermore the advice may revive parental sorrow and fear, or the advice may usurp the parents' "right to know" or "right to decide." We shall trace below how the teacher may be helpful in each of these eventualities.

Overwhelming advice: Parents of children with a handicap are frequently bombarded by innumerable and bewildering prescriptions. The tasks may be so numerous, so time-consuming, so onerous that the parents become discouraged and feel incapable of ever doing everything required. They may, finally, give up altogether. The parents of a multiply handicapped child—one who may need to wear glasses and hearing aids and orthopedic prostheses—may feel overwhelmed by the multiple prescriptions of experts one of whom appears to see the eyes along, another, the ears alone, and another, the limbs alone; whereas the mother sees the whole child. The teacher can be supportive by acknowledging frankly that the demands are many, that parents are busy with other responsibilities, and that the practical tasks of parenting a handicapped child at times seem overwhelming. This kind of sympathy, rather than constant stern reminders, can give parents the support and the strength to continue.

Conflicting or incompatible advice: One important area where parents need support that teachers can give is that of resolving differences of opinion between two different professionals representing the same discipline. An example of this kind of bind in which parents may be caught can be seen when two audiologists or hearing aid dealers give differing prescriptions for audiological help (the kind and number of hearing aids, the time of its introduction, or type of auditory training may be quite different.) Teachers need some degree of expertise in areas related to their specialty in order to be able to advise parents when this kind of situation arises. Where the teacher feels incapable of advising between two different "prescriptions" she can at least acknowledge how difficult the situation involving conflict is for the parents or suggest ways for parents to arrange a conference with the conflicting professionals, emphasizing the need for calm discussion of the differences. Often, if parents can vent their feelings about these differences they are better able to approach a consultation with equanimity, eliminating some of the antagonism that makes professionals less able to suggest a compromise.

Advice which revives parental sorrow and fear: Teachers need to be aware that some behavior on the part of parents that appears to be careless or irresponsible (such as "forgetting" to have new glasses or hearing aids fitted) is in fact an emotional response to the sorrow surrounding the diagnosis. For example, the teacher may encounter a parent who vehemently proclaims an acceptance of hearing aids yet whose child repeatedly comes to school without one. A gentle reminder of the discrepancy, followed by sensitive questions about what happens when the hearing aid is placed on the child, may elicit feelings of anger at having a visibly defective child, or anger with professionals who failed to cure the hearing defect. Such open feelings may enable the parent to behave more constructively, whereas such exhortation as "You know the child must wear the hearing aid" will only make the parent more anxious, confused and defensive. The teacher or counselor may need to wait until the parent has come to terms with his feelings before

making an issue of the attitudes toward the hearing aid, the glasses, the crutches, or the wheelchair.

Advice that usurps parents' "right to know" or "right to decide": Teachers are learning that it is important that they not usurp parental roles in establishing communication with the child, and not attempt to substitute their preferred communicative mode, language, or dialect for the one used by the child's family. Teachers must also guard against usurping parents' "right to know" of differing approaches to the treatment of the handicapped child, and parents' "right to decide" about the treatment their child receives. The issue of communicative mode has even greater importance for the deaf child because the difficulty of learning language is at once the result and the chief symptom of his handicap. Thus, teachers may face an important dilemna in offering information and advice about the choice of oral, manual, or combined forms of communication with deaf children. Often the solution of the dilemna is reached with the intent of providing the greatest immediate comfort and support for parents, but the long-range result can be the opposite of that intended if parents' "right to know" and "right to decide" are not respected.

Thus teachers of deaf children may avoid telling parents that there are honest differences of opinion in the area of deaf education, discussing only the method that they themselves prefer. Later when parents learn from others about these differences they may feel excluded, and recriminations from parents are often heard when the children become older. Secondly, the teacher may describe alternative methods, but display obvious contempt for those different from her own. The parents then experience conflict, especially where two experts with alternative methods have significant contact with the child. One psychiatric principle espouses the idea that adults may disagree openly about some vital issue without creating conflict or difficulty for the child. However, if the disagreement is accompanied by a lack of respect or even contempt, the child is caught in a conflict he cannot resolve. Thirdly, the teacher may offer complete information about differing methods to parents, may evidence respect for each one, but be reluctant to commit herself to any one method, believing that this increases parental choice. It may appear that this approach creates ambiguity for parents, and the feeling that teachers are unwilling to be completely honest. Sometimes in using this method teachers make vague references to treating individual children by differing methods, and in some instances are reluctant to explain in any general terms the characteristics of the children for whom the individual methods may work best. Parents of very young children can become justifiably impatient with this approach since they cannot always know what their child will be like at a later developmental stage.

Our Center in San Francisco emphasizes mental health services and research rather than offering educational programs except on a very limited demonstration basis. For the parents and children participating in research projects, advice is not a part of our contact since we are learning about the developmental stages of deafness from them. (Services are available upon request to these families as to any other, however.) For parents who come seeking help and advice in making decisions about their young deaf child, we feel that it is our obligation to state that we have concluded that the early use of sign language in a non-confusing setting and in conjunction with auditory and speech training will enhance the acquisition of speech and language and will contribute to the social and emotional development of the deaf child. We believe that it is our further obligation to share with parents the research, the theory, the experience, and the observations that have led to this point of view. Secondly, we feel that we must make it clear that there are many professionals who feel strongly that the use of manual communication will interfere with the deaf child's ability to acquire speech. Thirdly, we make it clear to the parents that our support of their efforts, and the provision of

mental health services to them and their child is not dependent upon their use of manual communication.

Our efforts at parental support in establishing communication include the constant and conscious attempt to diminish conflicts between parents and other professionals that may be related to communicative mode. The most important and basic principle in the area of communication conflicts is that professionals need to find creative ways of encountering others, of sharing controversial information in a relaxed and non-threatening atmosphere, and of developing genuine respect for opposing points of view.

Expectations for Present and Future

An understandable parental desire for the child to be like them or to surpass them in achievements is often accompanied by a massive attempt to mold the child into normalcy, intactness, and conformity. Sometimes these wishes result in an effort to eliminate the defect itself and the differences that it causes. Certainly the effect of a handicap can be diminished by early intervention and education, but the deaf child typically does not become like a hearing child. The blind child does not become like a sighted child; the retarded child does not become like a normal child. Exhortations to become normal are frequently seen by the child as nonacceptance, not only of his handicap, but of his very being.

Two main tasks fall to the teacher of the young child with a defect. One is to provide a realistic, non-rosy, but non-somber, picture of the achievement and adjustment of adults with a similar handicap. This can be established by providing literature and also more importantly through contact with adults of similar background. For example, successful deaf adults can provide a spurt of hope and self-esteem to parents and deaf children identical to the demonstrated spurts of self-esteem that occur when successful black adults are introduced into black children's school rooms (Pettigrew, 1964). It may be true that many hearing parents will have a traumatic reaction to adult deaf speech, but we feel that this will be transient and less detrimental than a failure to acknowledge reality. Many parents of older youngsters known to us have expressed deep regret for the years when they held tenaciously to the belief that their deaf child would grow into a seemingly hearing youngster. They now feel that this distorted expectation interfered with effective early parenting.

The second task of the teacher is to help the parents to diminish their attempts to mold the child into normalcy. In their poignant search for speech many parents extend the training of the child far beyond his physical or emotional capabilities. The expectations for speech also frequently result in maneuvers on the part of the parents that evoke massive negativism toward speech or even eye contact with the parent. In general, a teacher can sensitively explore what normalcy means to the parent, place normalcy into a realistic realm, and provide steps that will be effective and not counterproductive. She can help the parent to understand that while a handicap is not the *only* thing that matters it continues to be important. Other characteristics are more important: a child is always "a child first," although a handicap produces additional needs in both the child and the parent.

Emotional Support in Achievement of Early Tasks of Social-Emotional Development

Teachers in early childhood education programs inevitably become resources for parents in answering questions about child-rearing. These questions often seem to require a concrete and definitive reply, but are not handled most effectively by concrete and definitive answers. There is increasing leeway in "acceptable" child-rearing practices, in regard to the time of introduction of different kinds of foods, the preferred response to a baby's cry, to toilet training, to discipline. Widely varying practices produce well-adjusted and

productive children. In most mother-child activities, it seems that it is not the content that makes the differences, but the feeling of comfort that the mother experiences from her unique style, which she then communicates to her child (Schlesinger, 1969).

Thus, one function that the teacher can perform is to reinforce parents in continuing the child-rearing practices with which they feel comfortable. Often parents wonder if the things that "feel right" to them in dealing with their non-handicapped children are also appropriate for their handicapped children. This basic concern is a component of many poignant requests for help with eating, sleeping, and discipline problems. Teachers must be wary of imposing their own cultural or individual biases on their responses to parents' questions. Within this context, and with these general points in mind, it is still possible to suggest ways in which teachers can be helpful to parents in terms of emotional support. One of these is the very general point of helping parents in carrying out those child-rearing practices with which they do feel comfortable. Another way to provide support is to give parents an opportunity to discuss, to "ruminate", about their child's behavior and their own responses with a sympathetic, non-judgmental individual outside the family who has some distance from the immediate day-to-day problems that arise in the home. In terms of discipline for the young child, one principle that a teacher may find helpful is to remind parents that they are usually in a better position to discipline the child if they do not set up conditions that they do not intend to enforce, or that they find impossible to impose. For example, if parents are concerned about a child's eating habits, they might be tempted to tell him that he will not be permitted to leave the table until he has finished the food on his plate. If the child chooses not to finish his dinner, the parent has created a dilemma. The child *can* outwait the parent if a true battle of wills ensues. If, on the other hand, the parent makes finishing a certain amount of food a condition of receiving dessert, he can give or withhold the sweet.

A recurring theme that parents of handicapped children raise, either implicitly or explicitly, is that of establishing independence. It is a temptation for teachers and counselors to assume that parents of handicapped children are "over-protective." Frequently, it is difficult to draw the line between protection that is based on realistic limitations on the part of the child, and protection that is based on parental guilt and anxiety. Again, the opportunity to discuss specific examples with the teacher and with other parents can often help parents to arrive at their own definitions of over-protection and realistic caution. The frequent injunction for parents to "treat the handicapped child like any other child" is not truly helpful in cases where the handicap imposes realistic limitations on a child's performance. The failure of teachers (and other professionals) to recognize the true limitations imposed by the handicap can result in parents' scaling down their expectations for their normal children, in order to allow themselves to feel that they are treating all the children alike.

A frequent concern of parents with whom we work is that of handling temper tantrums effectively. In this area, there seems to be a wide range of behaviors that individual parents feel comfortable about accepting. One mother described how she successfully discouraged tantrums by putting a drop of Tabasco sauce on her finger and touching it to the child's tongue. Another mother told of putting a child under a shower fully clothed to discourage a temper tantrum; a week later the child placed herself under the shower apparently in an effort to stop herself from a fit of temper. Both of these tactics made some parents uncomfortable, while others viewed them as interesting possibilities for future reference. It is important for professionals to find ways of saying to parents, "This may not be my way, but if you feel comfortable about it, if the child does not suffer, I will accept your way of behaving and hope you can accept mine."

BIBLIOGRAPHY

Beck, H.L., Counseling parents of retarded children: *Children*, 1959, 6, pp. 225-230.

Boles, G., Personality factors in mothers of cerebral palsied children: *Genetic Psychology Monographs*, 1959, pp. 159-218.

Caplan, G., *Principles of preventive psychiatry*. New York: Basic Books, 1964.

Erikson, E.H., *Identity and the life cycle*. New York: International Universities Press, 1959.

Erikson, E.H., *Childhood and society*, New York: Norton, 1963.

Erikson, E.H., *Identity, youth and crisis*, New York: Norton, 1968.

Farber, B., Effects of a severely mentally retarded child on family integration: Monographs of the Society for Research in Child Development. 1959, No. 71.

Fellendorf, G., and Harrow, I., Parent counseling 1961-1968: *Volta Review*, 1970, 72, No. 1, pp. 51-57.

Meadow, K.P., Parental response to the medical ambiguities of congential deafness: *Journal of Health and Social Behavior*, 1968, 9, No. 4, pp. 299-309.

Pettigrew, T.F., *A profile of the Negro American*. Princeton: Van Nostrand, 1964.

Ross, A.O., *The exceptional child in the family*. New York: Grune and Stratton, 1964.

Schlesinger, H.S., "A child first," *Volta Review*, 1969, 71, No. 9, pp. 545-551.

Schlesinger, H.S., and Meadow, K.P., *Sound and sign: Childhood deafness and mental health*, Berkely: University of California Press, 1972. (in press).

Wright, B.A., *Physical disability—a psychological approach*. New York: Harper and Row, 1960.

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Chapter III
Exchanging Information

Information Exchange

Information exchange as it applies to parent programming may best be defined as a process by which parents become cognitively aware through the interaction with others (e.g., teachers) of the many aspects of their child's world. It can take place through formal professional-parent contact, and, for this kind of exchange to be most effective, information needs to be imparted in a planned, systematic manner. Parents should be informed initially about the rationale, objectives, and activities of the program in which their child is enrolled, because of the new effort toward total parent involvement in programming for their own children.

There are a number of essential parameters to be included in the framework of a planned, systematic program for parent information. They are (1) normal development, (2) handicapping conditions, (3) behavior management, (4) intervention procedures, materials, and equipment which can be used, not only in the clinical setting, but in the home setting. It is important to make plans to provide training in each of these areas as it applies, not only in the center situation, but also in the home. The delivery of the information may take place in conjunction with the parent program, through home, or follow-up visits. In order for parents to understand and manage their handicapped child and become contributing members of the intervention team, it is important that they receive and give information about each of these parameters.

Needs Assessment

It is important to remember that, when determining the parents' need for a program, there are many avenues for revealing information to parents. Some of these are information given directly to the parents by a

professional, interchange among the parents, and feedback from the parents to the professionals. The value of interchange among parents is that they learn from each other's experiences. Likewise, feedback from the parents or questions posed by the parents serve to give ideas for program improvement and further discussion within the group. It goes without saying that it is of the utmost importance for professionals to *listen* to what parents have to say!

During the initial planning stages for parent programming, it is necessary to determine what kinds of information the parents feel is important. Our program, The University of Wyoming Communicative Disorders and Parent Training Program, has as a component an intensive eight-week summer session. As this project serves the entire state of Wyoming, parents and children live on campus and visit the clinic daily. Before our parent program was initiated, we sent a questionnaire to all potential participants asking them to rate as very important, important, or not very important the following list of program suggestions:

_____ Assisting in the group activities with the children such as creative play, arts and crafts, swimming, and snack programs.

_____ Observing your child's speech and language sessions.

_____ Participating in group parent counseling sessions with social worker or psychologist.

_____ Learning to assist in your child's speech and language development.

_____ Participating in individual parent counseling sessions with social worker or psychologist.

_____ Receiving information about all aspects of normal child development.

_____ Receiving information about speech, hearing, and language problems.

_____ Receiving information about normal speech and language development.

_____ Learning to cope with your child's specific problems.

_____ Receiving an explanation of evaluation procedures used for identifying speech, hearing, or language difficulties.

Space was also provided on the questionnaire for additional suggestions for programming. The parents were assured that the information they provided would serve as group data only and their answers would remain confidential. The ratings the parents assigned to our program suggestions did serve as a basis for structuring our parent program. This particular checklist was structured for the parents of speech, hearing, and language impaired children but could well be adapted to parents of children with any handicap.

If a parent program is to be successful, assessment of the needs of the parents must be a continuing process. There are a number of possible ways to obtain information from parents for this reassessment. One is from verbal comments made by the parents. The second is by administering questionnaires which the parents are asked to complete at regular intervals during the program. The third is to form a parent advisory council to meet at regular intervals to help with programming suggestions. The parent advisory council is made up of three or four parents from differing socio-demographic levels who have voting power on policy decisions. Our parent advisory council, for example, helped us formulate one of our questionnaires. Those who are initiating parent information programs should plan to use all three of these methods—verbal comments from parents, question-

naires, and a parent advisory council, for conducting their needs assessment. With this type of information, it is possible for the staff to continually restructure a more effective parent information program.

Program Constraints

In designing a parent information program, professionals must consider that there are physical, economic, and psychological constraints which should be considered and planned for.

For example, you should be cognizant of the fact that it may be difficult for parents to participate on a regular basis because there may be siblings in the home that the parents cannot leave in order to participate in the program. Consideration should be given to providing day care or babysitting services for these siblings. Perhaps the lack of transportation to and from the center may prevent some parents from participating. The solution to this problem may require not only making arrangements for transportation but also providing monies for transportation. It is important also to remember that the inclusion of as many family members as possible increases the effectiveness of this information in the home setting. Whenever possible, not only mothers, but fathers, grandparents, and older siblings should be informed in these respective groups.

Problems in program delivery is another constraint and a decision-making or planning process must be incorporated as an ongoing activity. It is important to involve as many people as possible in this process—parents, staff, and director. Decision-making or planning must be carried out in regard to (1) the frequency of the information-giving sessions, (2) the coordination of staff members presenting information—who will do what and when? (3) the sequence and continuity of information to coordinate with other facets of parent-child programming, (4) the arrangement for audiovisual and supplementary materials to be available when needed, and (5) the consideration of how the information is going to be used by the parents and other family members in the home setting.

Program Design

From our experience in working with parents, we feel that the following areas should be included in information exchange programming: (1) information concerning the rationale, objectives, and activities of both the parent and child programs; (2) information on normal development; (3) information about handicapping conditions in children; (4) information about behavior modification; (5) exposure to and/or experience with intervention procedures, materials, and equipment which can be used in the clinical situation or home setting; and (6) follow-up into the home setting.

We have already discussed ways to conduct the dissemination of the information in (1). In designing our parent information program for items (2) through (6), we found it necessary to collect programming ideas from many sources; in many cases, we developed our own ideas. The following is an overview of methods and materials incorporated into our parent information program.

Normal Development

One of the most helpful programs that we have found to present the concept of normal development is the workshop series, *Teach Your Child to Talk* (Pushaw, Collins, Czuchna, Gill, O'Betts, and Stahl, 1969). This program includes a publicity presentation, materials for three workshops, and an evaluation form. The first workshop deals with normal development in infants from birth to twelve months; the second workshop deals with normal development from twelve months to three years; the third deals with normal development from three to five years. Each of these workshops is designed to cover about two hours'

time. However, one can easily break each of the workshops into several segments to cover two or three different parent meetings. The materials included in the kit are: slides, tape recordings, a 16mm color film, a workshop manual, pamphlets entitled *Teach Me To Talk*, (Czuchna, 1969) and a parent handbook. The pamphlets and handbook may be purchased in quantity. Dependent upon the frequency of this kind of presentation in your program, these may be all the materials you need for information on normal development. However, because our program is scheduled for eight intensive weeks during the summer, we have found it is necessary to include additional materials. Many low cost films, pamphlets, and other materials (Metropolitan Life, 1970; Children's Bureau, 1968; Johnson, 1953; Boone, 1965; Jung, 1968) are available commercially for use in a parent information program. Dittoed handouts on various aspects of normal development (such as speech, language, social, and emotional) may also be compiled for dissemination to parents.

A further method of information exchange in the area of how children develop and function is to involve the parents as aides in our swimming, playground, and arts and crafts activities. Here the parents gain information by observing and interacting with the children in relatively normal types of activities. Through this aspect of the program parents are given a chance to apply the things that they learned in the classroom to the children they see.

Handicapping Conditions

The types of children enrolled in our program are those with speech, hearing, and language handicaps. Therefore, the information we give to our parents about handicapping conditions relates primarily to these disorders. A selection of materials for information on handicapping conditions includes: (1) films (Harper and Row, 1970; Clarke School, 1970; MISSCA, 1968; University of Iowa, 1956); (2) pamphlets (NIH, 1970; Northcott, 1970; Pennington, Corbin, and James, 1966; Sayre, 1966); (3) other references (Irwin, 1968; Battin and Haug, 1968; Van Riper, 1961; Johnson, ed., 1958; Screiber, 1956). Dittoed materials on handicapping conditions may be used for handouts for parents. Not only do we use these and other materials in our group sessions, but we also have them available to loan to parents to use at home. These films, pamphlets and books can be obtained by writing directly to the publishers. The films are available for a nominal rental fee, the pamphlets and books are relatively low cost.

Another effective method for informing parents about handicapping conditions is through the use of video tape. With the parents' permission, we video-taped various children in actual therapy sessions and used this as a spring-board for discussion concerning etiology and ramification of various speech, hearing, and language disorders.

Behavior Modification

Information about behavior modification serves a two-fold purpose in our program: (1) the parents become aware of methods to manage such behaviors as whining, temper tantrums, and fear in the home setting; and (2) it serves as a background for the parents in observing, baselining, reinforcing, and graphing behavior.

The basic tool we utilize in this phase of our program is *Living With Children: New Methods for Parents and Teachers* (Patterson and Gullion, 1971). This book is written in the form of programmed instruction and teaches parents to understand and manage behavior which is distressing to them. A second programmed text that we found to be valuable is *Parents are Teachers: A Child Management Program* (Becker, 1971).

A number of other pamphlets, films, and books are also made available to the parents in this program. The selection of these materials must be

necessarily dependent upon the philosophy of the individual program.

Exposure to and Experience with Invervention Procedures, Materials, and Equipment

This parameter is included in our program to give our parents a basis for working with their children not only in the clinical situation but in the home setting. We give information about, and practice in using such materials as the *Peabody Language Development Kit* (Dunn, and Smith, 1965, 1966, 1968; Dunn, Horton, and Smith, 1968); *Distar Language Program* (Englemann, Osborn, and Englemann, 1069); and *Learning to Develop Language Skills* (Sprugel, Nice, and Karnes, 1970). We also provide basic information about various instruments that are used to evaluate their children in order that the parents are able to understand the results of our evaluations.

We also give the parents opportunities to develop and create materials which they can use in the home situation. In the monthly newsletter, parents receive lists of materials to collect and bring to the summer session. The clinicians assist the parents in individualizing these materials according to their child's needs. A side-effect of creating these materials is that the parents develop skills in (1) making dittoed materials and transparencies, (2) learning to use various equipment such as the veri-fax machine, laminating machine, and opaque projector. The parents are also instructed, and have practice using such equipment as tape recorders, video cameras, slide projectors, and movie projectors.

Follow-up

Follow-up, or visits in the home setting, may be an integral part of an ongoing parent program or it may be a type of activity which follows intensive programming for parents. In our particular setting, follow-up in the home setting took place after intensive programming for parents on a daily basis for eight weeks.

Home visits cover not only parent information but all aspects of parent-child programming. They provide an ideal time to observe the parent-child interaction in the home setting; for example, what kinds of discipline is the parent using with the child, what kinds of stimulation is the parent giving the child. These visits are helpful and necessary to answer questions or help solve problems that the parent may be having. Dependent upon program philosophy, this is also the time to work cooperatively with the parents in developing objectives for home training. The person who is making the home visits should demonstrate to the parents the skills the child is expected to develop before the next visit and review any materials which will be used in the program. Continued dissemination of materials and information is another aspect of home visits. This is particularly important when the parents do not live within commuting distance of the center.

Keeping in touch with the parents when they are away from the center may be accomplished through a newsletter. This communication may include news from other parents and children, listing of new books, pamphlets, or materials, ideas for constructing materials, and therapy ideas.

Program Evaluation

In this age of accountability it is important to determine how effective any programming is. In evaluating any facet of parent programming, it is important to convey to the parents that they are not necessarily being evaluated, but that the effects of the program are being evaluated.

In evaluating the effectiveness of our program, we use several instruments. Our parents are given the Parent Attitude Research Inventory (Schaefer and Bell, 1958) upon entering the program. They also fill out a feedback questionnaire which is rated on the

Likert scale. Those who are initiating programs will want to develop their own scales which are pertinent to the objectives and activities of their own program. It is not really important whether the scale is based on 1-5 or if it is just a questionnaire which requires "yes", "no", or "no opinion" answers. The importance of a scale lies in the fact that staff and/or parents have had a hand in its evolution.

During the actual programming, the parents are asked to complete a weekly pre- and poststudy guide. To assess their understanding of the program, we utilize a checklist which is filled out when the parents observe our clinicians working with their child. In the home setting, we assess the effectiveness of the parents' intervention through the use of a follow-up instrument developed by Caster, Dublinski, and Grimes, 1972.

In order to keep any program "on target", evaluation must be an integral aspect. It is important to remember that if parent do not understand our information it is the fault of our programming and not the fault of the parents.

BIBLIOGRAPHY

Battin, R., and Haug, C.O., *Speech and language delay: A home training program.* Illinois: Charles C. Thomas, 1968.

Becker, W., *Parents are teachers: A child management program.* Illinois: Research Press Co., 1971.

Boone, D.R., Infant speech and language development. Washington, D.C.: Volta Bureau, 1965.

Bryant, J., Helping your child speak correctly. Public Affairs No. 445, New York, 1970.

Caster, J., Dublinski, S., and Grimes, J., *Increasing intervention effectiveness through improved communication.* Des Moines, Iowa: Special Ed., State Dept. of Ed., February, 1972.

Cavendish, M., Ltd., Story of life. 58 Old Compton Street, London W IV, 5 PA, England, 1969-1970.

Czuchna, G., Teach me to talk, N.Y., CEBCO Standard Publishing Co., 1969.

Dunn, L., and Smith, J.O., Peabody language development kit, no. 1, Circle Pines, Minnesota: American Guidance Service (1965).

Dunn, L., and Smith, J.O., Peabody language development kit, no. 2. Circle Pines, Minnesota: American Guidance Service (1966).

Dunn, L., and Smith, J.O., Peabody language development kit, no. 3. Circle Pines, Minnesota: American Guidance Service (1968).

Englemann, S., Osborn, J., and Englemann, T., *Distar language I*, Chicago, Illinois: Science Research Associates, 1969.

Irwin, R.B., *A speech pathologist talks to parents and teachers.* Pittsburgh, Pennsylvania, Stanevix House Publisher, 1968.

Johnson, W., Is my child normal: an open letter to a normal mother and father. Interstate, Danville, Illinois, 1968.

Johnson, W., *Speech problems in children.* New York: Harper and Row, 1953.

Jung, C., *Inner world of childhood.* Signet Books, New York, 1968.

Long, C.L., Will your child learn to talk correctly? Illinois, Interstate, 1968.

National Institute of Health, Learning to talk. Bethesda, Maryland: Information Office, Hinds, 1970.

Northcott, W., Reading list for parents. *Volta Review*, 1971, 73(3), 186-189.

Patterson, G., and Gullion, M.E., *Living with children: New methods for parents.* Champaign, Illinois: Research Press, Inc., 1971.

Pennington, R., and James, E., For the parents of a child whose speech is delayed. Illinois: Interstate, 1966.

Pushaw, D., Collins, N., Czuchna, G., Gill, G., O'Betts, G., and Stahl, M., *Teach your child to talk.* Cincinnati: CEBCO Standard Publishing Co., 1969.

Sayre, J.M., Helping the child to listen and talk. Illinois: Interstate, 1966.

Schaefer, E.S., and Bell, R.Q., Development of a parental attitude instrument. *Child Development*, 1958.

Screiber, F.R., *Your child's speech: A practical guide for parents for the first five years.* New York: G.P. Putnam, 1956.

Sprugel, C., Nance, I.D., and Karnes, M.B., *Learning to develop language skills*, Springfield, Massachusetts: Milton Bradley Co., 1970.

United States Department of Health, Education, and Welfare. Your child from 1-6. Children's Bureau Publications, No. 30, 1968.

Van Riper, C., *Your child's speech problems.* New York, 1961.

FILMS

Clarke School, *Everything but hear.* Northampton, 1970.

Darley, F., and Van Riper, C., *Introduction to speech problems.* Wayne State University, 1965.

Denes, P., and Pinson, E.N., *The speech chain.* Bell Telephone Laboratories, 1964.

Harper and Row, *Language disorders.* 1970.

Harper and Row, *Articulation disorders.* New York, N.Y., 1970.

University of Iowa, *Children with cleft palates.* 1970.

Metropolitan Life Insurance Company, *A time for growing.* New York, 1970.

Metropolitan Life Insurance Company, *If these were your children.* New York, 1970.

Minnesota Society for Crippled Children and Adults, *Seven for Suzie.* 1968.

APPENDIX A

Below are listed ten suggested areas of instruction for parent training in our expanded summer clinic program. Please rate each area on its importance to you as parents. Place a check in the appropriate box.

	Very Important	Important	Not Very Important
1. Assisting in group activities with the children such as creative play, arts and crafts, swimming and snack programs.			
2. Observing your child's therapy session.			
3. Participating in group parent counseling sessions.			

4. Learning to assist in your child's therapy.

5. Participating in individual parent counseling sessions.

6. Receiving information about all aspects of normal child development.

7. Receiving information about speech, hearing and language disorders.

8. Receiving information about normal speech and language development.

9. Learning to cope with your child's specific problems.

10. Receiving an explanation of evaluation procedures used for identifying speech, hearing or language disorders.

Other suggestions for programming will be appreciated. Please be specific.

Name _____

Child's Name _____ Child's Birthdate _____

Mailing Address _____

Telephone _____

Please fill out the information above and return in the self-addressed stamped envelope.

I am interested in applying for this program for my child and myself.

APPENDIX B

Directions: Please rate yourself as fairly and accurately as possible on the following questions. A scale from 1 to 5 is provided with (1) being the lowest or poor, and (5) being the highest or excellent. Circle the rating you believe would be closest to your knowledge or ability.

1. Knowledge of normal speech and language development:

   1 2 3 4 5

2. Knowledge of speech and language disorders:

   1 2 3 4 5

3. Understanding of behavior modification techniques:

   1 2 3 4 5

4. Ability to assist my child in overcoming his/her speech problem:

   1 2 3 4 5

5. Opinion of the follow-up program:

   1 2 3 4 5

The administration desires to judge the effectiveness of the program for improving future programs, and your help will be greatly appreciated.

PRE AND POST STUDY GUIDE FOR NORMAL DEVELOPMENT

1. The infant's vocalizations during the first two to three weeks of life are termed:

   a. gurgling
   b. cooing
   c. reflexive
   d. differential
   e. linguistic

2. True speech:

   a. is developed
   b. begins somewhere between the 12th and 18th month
   c. does not begin until the child understands speech
   d. a and c
   e. a, b, and c

3. At about six or seven weeks of age, the infant begins to show by his reactions that he is aware of the sounds he is making. This is termed:

   a. awareness
   b. babbling
   c. responsiveness
   d. reactionary
   e. maturation

4. At about nine or ten months of age, the child may be heard imitating sounds which others have made, and which are prevalent in his environment. This is termed:

   a. environmental reaction
   b. imitation
   c. echolalia
   d. bradylalia
   e. acalculia

5. _____ is defined as repetition of heard sounds or sound combinations.

   a. perservation
   b. proprioception
   c. idioglossia
   d. lalling
   e. kinesthesia

6. When a child has developed "inner language", we say he has developed:

   a. thinking
   b. inflection
   c. occlusion
   d. internalization

7. When a child has developed "receptive language", we say he:

   a. receives
   b. lateralizes
   c. operates
   d. understands
   e. commentates

8. When a child develops "expressive language" we say that:

   a. he says one or two words
   b. he must have first developed inner and receptive language.
   c. he has also developed all of his motor skills
   d. a and b
   e. a, b, and c

9. Before each of the following, put an *A* if the normal development occurs between 12 to 18 months; a *B* if the normal development occurs between 18 to 24 months; a *C* if the normal development occurs between 2-3 years; a *D* if the normal development occurs between 3 to 4 years; or an *E* if the normal development occurs between 4 to 5 years.

   _____ has completed 90% of the job of learning how to talk.

   _____ will (1) distort a sound or substitute one sound for another or (2) completely leave a sound out of a word.

   _____ is eager to learn names for everything.

   _____ frequently uses two-word sentences.

   _____ is able to understand most of what you say in its complicated adult form.

   _____ uses jargon.

   _____ may exhibit normal non-fluency.

   _____ may play with sounds by rhyming words.

   _____ sentences average 4-5 words.

   _____ can tell you what he wants by pointing and saying a few words.

10. Check the activity below which would *least* likely be included in a parent involvement/training program dealing with handicapped children.

_____ information about normal development
_____ opportunities to make materials for home training
_____ "awareness" groups
_____ information about handicapping conditions
_____ opportunities to observe and assist in their child's training program
_____ training in counting behaviors and behavior modification
_____ information about nutrition and opportunities to learn to prepare balanced meals
_____ working as aides in supplementary programs for children

11. Check the materials or equipment below (3) which would be *least* useful in training parents of handicapped children.

_____ *Living With Children* by Patterson and Gullion

_____ "Dr. Spock"

_____ *Getting Ready to Read* published by Houghton Mifflin

_____ *Parent Attitude Research Inventory* by Sheafer and Bell

_____ Video-tape equipment

_____ Sewing machine, cotton material, socks, arts and crafts materials

_____ Golf counters

_____ *Better Homes and Gardens Cookbook*

COMMUNICATIVE DISORDERS & PARENT TRAINING PROGRAM

Questionnaire

	Yes	No
1. Do you feel that you benefited from the Communicative Disorders and Parent Training Program?	_____	_____
Have you been able to use the knowledge you gained this summer?	_____	_____

2. Do you feel that your child benefited from the Communicative Disorders and Parent Training Program? ____ ____

   Has your child continued to show progress since returning home? If not, please explain. ____ ____

3. Children's Program:

   Do you feel that your child had enough individual therapy sessions? ____ ____

   Do you feel that your child benefited from the group language sessions? If your answer is no, please explain. ____ ____

Please list other changes you would like to see made in the children's program.

4. Parent Program:

   Class Organization:

   Would you like to see more formal lectures by staff members? ____ ____

   Would you like to have more parents' participation in planning or programs? ____ ____

   Would you like to have smaller groups? ____ ____

   Therapy Materials:

   Do you think a Parent Committee should help plan and oversee making of materials? ____ ____

   Do you think materials should be more geared to child's age and problem? ____ ____

Please comment on other changes you would like to see regarding construction of materials.

Observing and assisting in therapy:

   How many days of instruction do you feel you need before beginning observation?

   ____ 2 days;____ 5 days;____ 10 days;____ other? (state)

   Do you feel it is important to begin by observing children other than your own? ____ ____

How many days do you feel that you need to observe before beginning to assist in therapy?

_____ 5 days;_____ 7 days;_____ 10 days;_____ other (state)_____

Please comment on other changes you would like to see regarding observing and assisting in therapy.

	Yes	No
Volunteers for swimming, arts and crafts, and playground:		
Should a committee of parents be involved in planning the above activities?	____	____
Please comment on other changes you would like to see in these programs.	____	____
Teacher-parent relationship:		
Would you like to have a definite time scheduled each week to meet with your child's therapist?	____	____
Do you need more help from the teachers in planning therapy activities?	____	____
Please make other comments as to how the teachers can be more helpful in the parent training program.		
5. Would you like to see a definite time scheduled each week for each individual mother to meet with the psychologist?	____	____
6. Would you like to see the discussion groups with Mrs. Boyer (social worker) continued?	____	____
7. We are particularly anxious to learn how we can make dorm life a more pleasant experience. Please make suggestions for improving this aspect of the program?		
8. Where did you hear about the Communicative Disorders and Parent Training Program? What suggestions would you make for informing other parents about this program?		
9. Follow-up Program:		
Do you feel that members of the follow-up staff are visiting you often enough to be helpful?	____	____
Have staff suggestions been helpful to you?	____	____

Have arrangements for other services for your child (regular speech therapy, physical therapy, etc.) been satisfactory? If no, please explain. ____ ____

Please make other comments for improving the follow-up program. (on back)

Please make other comments for improving the follow-up program. (on back)

PROGRAM EVALUATION

1. As a result of participating in this program, I feel that my child:

   Has shown improvement in speech and language skills _____

   Has shown little or no improvement in speech and language skills _____

   Please explain:

2. As a result of participating in this program, I feel that I (as a parent):

   Have gained in my understanding of my child's disability and my ability to help him _____

   Have gained little or no new understanding of my child's disability and feel no better able to help him with it than I was before I came to the workshop _____

   Please explain:

3. What parts of the program did you find to be the most helpful and why?

4. What parts of the program did you find to be least helpful and why?

5. What changes would you recommend to be made in the program for next year?

Please check one of the following:

_____ I participated in almost all of the program.

_____ I missed more than five days of the program (or did not participate in full day sessions.)

_____ I participated in less than half of the program.

Audrey Simmons-Martin

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Chapter IV

Facilitating Parent-Child Interactions

Parent Involvement

A basic approach to furthering parent-child interaction is to help both parents, but especially mothers learn how to teach their young children at home. Involving parents in the teaching-learning process should be the major means of helping a handicapped child.

In helping to develop and expand the role of parents as their children's first and most influential teachers, the program must provide an opportunity for parents to learn about: (1) approaches to child-rearing; (2) ways to use ordinary elements in the child's environment as teaching tools and how to turn everyday experiences into learning experiences; (3) ways to encourage the children's language growth; (4) ways to promote social and emotional development; and (5) ways to find and use various resources in the community.

Each program should approach its objectives in its own way, but whatever the educational approach, some of its program components should focus upon assistance and support to the mother in her role as "teacher" of her child. The person who assumes that responsibility takes on a variety of roles, dependent on each parent's needs. That person can be at any one time: (1) *A reinforcer* because she must support everything good the mother does; (2) *an activity director* giving ideas to the mother who is unsure of what to do; (3) *a teacher* acting directly and specifically in teaching and demonstrating model activities; and (4) *an information seeker and giver* sharing information about the child's growth, development, toys, and activities in an incidental way. (Nielson & Jeff, 1972)

Originally, early education programs placed emphasis on the parents' understanding of their child and their performance of certain tasks for the general well being of the child. Gradually, however, the scope of interest has widened to take in a broader understanding of the parental role. The infant's capability for assimilating and processing information in his very early years as well as his capabilities for emotional and physiological involvement has been clearly documented. The growth and development of the infant into his adult potential are much too important to be ignored.

While parent involvement in child development programs is now seen as more than information receiv-

ing, the programs must aim toward increasing the understanding of parents at many levels of developmental learning and through many kinds of experiences so that they will achieve further personal growth and develop greater competence in dealing with their children. Of course, these goals must be applied realistically. We may not be able to bring about drastic changes in the personalities of parents or in child-care practices which have their roots, not only in individual knowledge, but also in the parents' own upbringing. But we must provide the opportunity for parents to gain greater knowledge of child developmental problems, of themselves, of family and community relations in order to enable parents to alter some of their own practices.

In the case of a handicapped child the greatest need from the beginning is parents who can understand the child's problems and adjust to them. He needs parents who, as a result of this understanding, foresee what his needs will be.

Helping Parents to Help Their Children

One major area needing immediate attention is the parents' coping with problems of hour-to-hour, day-to-day management. Too often we assume that because we have suggested ways of giving language, or have prescribed didactic exercises, we have really provided for the follow-through and, therefore, total care. Frequently, the overall suggestions for the child's day may be more worthwhile than fragmental instructions for speech and other activities.

Importance of Stimulating Environment

There is much evidence from the study of children brought up in institutions, such as orphanages, that an impoverished environment (that offers few toys, few contacts with adults, and generally low levels of stimulation), led to retarded intellectual and social development. Under ideal conditions the parents assume responsibilities for different aspects of the child's learning. Generally, the mother satisfies the child's physical needs and administers to his comforts. She provides security and understanding. The father, on the other hand, provides opportunities for his child to socialize through games, conversation, and other, often more physical activities in which male interests and feelings are projected. Needless to say, these ideal conditions do not exist in all homes.

Parents Mold Children, Children Mold Parents

Most research in the parent-child interaction assumes that there is a direct and discernible relation between the parents' behavior, attitudes, and personality and child behavior and personality. This might well be an oversimplification. It may be that the parents and children influence each other in a two-way fashion. The child's behavior may shape that of his parents as well as their shaping the child's. Normal children by the age of three months seem to have a very strong control over their parents. It has been said that the mother is a puppet to her three-month-old puppeteer. If that puppeteer is in fact a handicapped child it seems plausible that he may shape different patterns of behavior in his parents than would a normal child.

Rheingold (Rheingold and Bayley, 1964, 86-92) listed the home activities recorded in a normal environment in order of magnitude as: holds, talks, talks to, feeds, and, looks at face, as constrasted with those performed in an institution which were: holds, feeds, looks at face, and talks to. It becomes readily apparent that children with special needs present unique problems. For example, if the handicap is that of hearing or language impairment, the second and third activities of the mother might soon be extinguished. This is probably because she receives little or no encouragement from the deaf infant. He may not "coo", smile, or do any of the reinforcing stunts that the mother needs. Many parents have not had the

necessary training for specific types of infant stimulation.

Evidence is accumulating that parenting can be taught and that it is not solely instinctive. From experiments with animals it has been demonstrated that offspring denied "mothering" in their infancy developed maternal behavior themselves that was completely abnormal, ranging from indifference to outright abuse. The "mothering" behavior of those primates entrusted to wire surrogate mothers was inferior to those provided with cloth surrogates, but both were poorer mothers themselves than primates who had had their real mothers. (Harlow and Harlow, 1962, 2-10)

It is readily apparent that if a child has a speech or hearing problem there is some degree of breakdown in communication. This breakdown can lead to difficulties in interpersonal relationships which can lead to further breakdown in communication. The parent contributes to the child's problems and vice versa.

A Parent-Child Program—Its Goals and Methods

The primary objective of a parent-child program on a preschool level is to enable the child to achieve the maximum level of his abilities. The literature is replete with evidence of the parents' role, in particular the mother's role, in determining the child's achievement as an adult. Earl S. Schaeffer (1972) presents a good review of recent research in this area. The preschool years are widely acknowledged to be the most crucial years in the child's total development. If this is so for the "normal" child, it is all the more so for a handicapped child. Thus, the parent of a handicapped child must deal not only with his own feelings about the child's handicap, but also with the needs of the growing child who happens to be handicapped. The parent, during the child's preschool years not only seeks the resolution of guilt feelings and the "WHY" questions—"*Why* me?", "*Why* my child?"—but also seeks direction in meeting the needs of the child represented by the questions—"What do I do?", "How do I do it?"

Keeping in mind the primary objective of a parent-child program on a preschool level as stated above, the goals or objectives may be grouped into three categories: immediate, intermediate, and long-range. The immediate goals may be viewed as the gates or doors which provide access to the intermediate goals which in turn lead to the long-range goal. These goals may be presented in the chart found at the end of the chapter.

The Role of the Teacher

These objectives provide the basis for the activities of the teacher or counselor in the Home Demonstration Center. Because of the range of these objectives as well as the variety of situations and needs presented by the parents and their child, it becomes evident that the teacher, to meet these needs and objectives, must assume a variety of roles.

These roles include: (1) *listener*—many parents have no one else to whom they can talk about their concerns for their child, (2) *enabler*—the teacher through her activities enables the parents to achieve *their* own maximal functioning as parents, (3) *model*—through the teacher's interactions and activities with the child she provides the parents a role or roles to imitate, (4) *reality tester*—the parents often need a person outside of the family to help them test out the reality of a situation as it concerns themselves or their child, (5) *integrator*—the teacher enables the parents to pull the bits and pieces into a meaningful whole, (6) *interpreter*—the teacher puts professional jargon into language the parents can understand, (7) *resource person*—the parents have one person to check out such things as new information, new programs, as they relate to their child, and last but not least, (8) *teacher.*

Often there are siblings in the family setting

who need attention, consideration and information about their handicapped family members. [A series of studies relating to the siblings of retarded children has been done by Farber, (Farber, 1962)]

"Home" Demonstration

If we turn specifically to our attempts to understand the implications underlying the variations of parental attitudes, it becomes apparent that our procedures for getting them involved must be individually based. At Central Institute for the Deaf we have had a program for parents of deaf infants since 1958. Over that period of time our program has changed somewhat.

Originally, the parents came together to get the best information they could about their child's hearing problem, what they could expect of their children, and how to deal with his handicap. Soon it became clear that they needed that and more. They had needs themselves, as parents; they had their own attitudes, feelings, and expectations; they had goal-setting problems. They needed to focus on their role as shapers of their child's behavior and in particular his language behavior.

With young babies there is no possibility of formal teaching situations; the only effective way is to adopt a "natural" approach. All parents have many opportunities in their homes, moment-by-moment, for shaping linguistic and cognitive behavior. There is dressing, washing, feeding, playing. However, parents need help in translating what they are told to do into actually doing it in their own homes. Therefore we initiated another aspect in our program and that was a Home Demonstration Center which is a real home in appearance. It is an old house with two apartments, like any other one on the block. The apartments are furnished in "Sears Early Desperation" and are far from prestigious, but they are warm, inviting, and comfortable. The first floor apartment has a living room, dining room, kitchen and bedroom. On the second floor is a kitchen, a living-dining room, a bedroom, a child's room and a bath. All appliances work with some degree of regularity. The refrigerators, while not laden, are adequately full and, similarly are the cabinets and closets. In short, nothing is contrived. There are no offices, nor office or school paraphernalia around; these are in the Institute itself, a close half-block away.

Into this setting come the parent and child for an hourly session with a teacher of the deaf. During this time she attempts to help them learn to seize every opportunity for language input. Since our emphasis is helping first-rate-parents to develop, and not to create second-rate-classroom-teachers, we use only experiences that each mother would be doing in her particular home.

In her own home the parent is the teacher in the broadest sense of the term. Therefore in our Home Demonstration Center she demonstrates how well she is progressing while the real teacher makes appropriate comments. It is obvious that the latter has to be skilled in creating an atmosphere of ease, transforming apprehensiveness into creative energy and helping the parents feel the need for interaction with their child.

Because we do not want the children to grow up unstimulated in well-furnished pleasant rooms filled with a variety of expensive, meaningless toys, as is sometimes the case, we try to provide basic perceptual, sensory and, therefore, cognitive experiences. These experiences have verbal labels associated with them which in turn assist in mental storage of the language. Through his perception the child develops appropriate concepts and vocabulary associated with the experiences which have features in common. Mediated with similar language, the concept develops and the language is absorbed. In this way the child receives the data by which to induce the rules. For example, "washing" is a concept which has linguistic form: wash hands, wash face, hair, wash someone else's face, hands, etc., wash dishes, pots, pans, silver, wash clothes, wash the car, wash the dog, wash the

windows, wash the floor, etc.

The implements are soap, sponge, washcloth, mop. The features in common are water, soap, and rubbing action but the most important feature they have in common is the word "wash".

We hypothesize the word "wash", experienced in a variety of situations can be more readily learned by the child than the word experienced many times in only one situation. There are some interesting data available which confirm this hypothesis. (Kol'tsovs, 1962)

The appropriateness of the activity is part of our direction. (We have even had doubts about such things as our storing milk in a jar, when most children use a carton.) Part of this is discussed with the mother prior to her demonstration with her child of the task or tasks she has planned for the hour.

Frequently advice on good "mothering" is given. Certainly good mothering techniques are reinforced. When she does something to get her child involved, captures some of his language output, or anticipates his needs, we reinforce her with praise. Sometimes the teacher helps the mother with the toilet training, feeding, bathing, and even clothing.

Family Conferences

Siblings of the handicapped child come with mother whenever possible. While this may create havoc, for the teacher, this, after all, is the true situation that faces the mother at her home. We strive also to have contacts with the father as well as the mother. As was noted earlier, the presence of a handicapped child is likely to intensify family stresses. One effect may have been to decrease communication between the parents who may have developed very different views of the child. If we can set the pattern of forthright discussion about what the child did, can do, might do, and will do, we hope we might focus their attention and discussion into meaningful channels.

The teacher never assumes that a conference in which the parents nod their heads in apparent assent necessarily represents real understanding. The intense emotional bond between parents and child may preclude rapid attitudinal change. Genuine change is a time-dependent phenomenon resulting from continuous exposure of the parents to reality-oriented situations. In these sessions with the teachers, parents are encouraged to be themselves, to disclose their own thoughts and feelings. As Beasley stated,

> to the extent that parents themselves are granted acceptance and respect, they will be more free to give this to their child. . . . . Since the problems of a child in language and speech originate and exist in an interpersonal setting, modifications of this environment may be highly important if change is to take place. (Beasley, 1956, p. 319)

Group Education

Fundamental to the parent's understanding of the handicapping condition is his knowledge of the handicap. For this reason the program of parent groups continues as an essential part of the Institute's services. At these sessions the subjects are language development, hearing aids, behavior modification, genetics, and hearing. Some of the speakers have been deaf adults, the director, and the principal of Central Institute, child psychologists, and other parents.

Before we think about what parents gain from experience in groups we ask a question. What is it that they really need? There are some universal trends

that we have observed. Parents want, first of all, up-to-date and accurate scientific information in language they can understand regarding their children's handicap, what deviations from normal child development the disability will cause, the emotional aspects of the handicap, and the way the handicap may affect the children's personality and behavior. They want to know practical information about what they can do to help their child to develop to his greatest capacity, and what they may expect this capacity to be. In other words, they want to know how to manage now and what they have to look forward to.

These are the questions they often bring first to professional people, with a very strong sense of urgency. It is only later that they reveal that they need to know more about themselves, about their own widely conflicting, but normal, feelings, and their own special level of tolerance of the demands that are put upon them. They need to have help in recognizing both where they are weak and where they are strong so that they can turn to appropriate services for help as they are needed. They also want to know the effects that a handicapped child can have on the family as a whole—the strain this places on the marriage, the effect on other children as they are growing up.

Surely some of the *information* parents need can be made available to them through the printed word, and in lectures at large meetings. Yet we must always remind ourselves that these "formal presentations" have their limitations, that parents will take from such reading and talks only what they are *able* to take from them and that they may react to this material in ways that one cannot predict in advance.

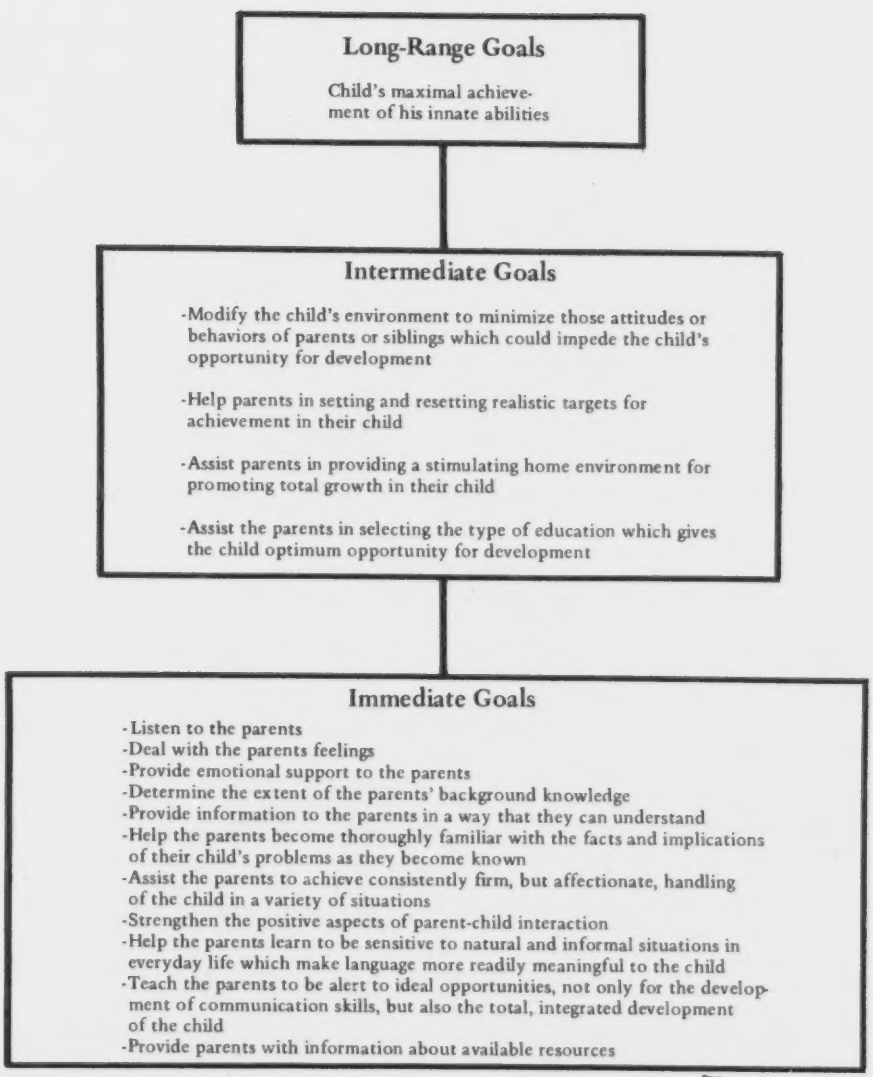
Parents Influence and Learn from Each Other

We must not underestimate the impact of one parent upon other parents in these group situations. In order to study this we sent trained observers to attend all our parent's meetings to take transcripts. We excluded from the meetings the audiologists and "parent teachers". There was quite a ventilation of attitudes such as doesn't happen often in the interaction between the professional person and the parent.

A variety of group experiences, however, needs to be provided in order to capture the parent at whatever stage of crisis reaction he might be. For example our mothers' group meetings range from small to large. One group is for the beginning mothers, another for the continuing mothers. A third group is the combination of the two. These all meet once a month. It should be noted that the parents proceed very quickly to enter into significant discussions and a rather immediate sense of identification from one parent to another takes place.

Summary

In summary, there has been a change in emphasis in programs for parents from didactic course work to total involvement. This involvement has shifted from parent becoming an instructor to parent being a teacher in the broad sense. Knowledge relative to the handicap is still essential but parents need help in parenting. They need to recognize the opportunities offered constantly in the home and the impact of their child on them and the family. Professionals need to be alert to the range of emotional periods through which parents pass. Recognizing the levels, they must accept parents in their present stage and move from there. A suggested program of a home demonstration was described. Not to be neglected also are group opportunities for ventilation and exchange.


Long-Range Goals
Child's maximal achievement of his innate abilities
Intermediate Goals
-Modify the child's environment to minimize those attitudes or behaviors of parents or siblings which could impede the child's opportunity for development
-Help parents in setting and resetting realistic targets for achievement in their child
-Assist parents in providing a stimulating home environment for promoting total growth in their child
-Assist the parents in selecting the type of education which gives the child optimum opportunity for development
Immediate Goals
-Listen to the parents
-Deal with the parents feelings
-Provide emotional support to the parents
-Determine the extent of the parents' background knowledge
-Provide information to the parents in a way that they can understand
-Help the parents become thoroughly familiar with the facts and implications of their child's problems as they become known
-Assist the parents to achieve consistently firm, but affectionate, handling of the child in a variety of situations
-Strengthen the positive aspects of parent-child interaction
-Help the parents learn to be sensitive to natural and informal situations in everyday life which make language more readily meaningful to the child
-Teach the parents to be alert to ideal opportunities, not only for the development of communication skills, but also the total, integrated development of the child
-Provide parents with information about available resources

BIBLIOGRAPHY

Beasley, J., Relationship of parental attitudes to development of speech problems. *Journal of Speech and Hearing Disorders.*, 1956, 21, pp. 317-321.

Bowlby, J., The nature of child's tie to his mother. *International Journal of Psychology*, 1958, 39, pp. 350-373.

Elliott, L., and Armbruster, V., Some possible effects of the delay of early treatment of deafness, *Journal of Speech and Hearing Research.*, 1967, 10, No. 2, pp. 209-224.

Farber, B., Effects of severely mentally retarded child on the family. Trapp & Hamelstein (Eds.), *Readings on the Exceptional Child.* New York: Appleton-Century-Crofts, 1962, pp. 227-246.

Harlow, H., and Harlow, M., Social deprivation in monkeys. *Scientific American*, 1962, p. 2-10.

Kol'tsovs, N.M., The formation of higher nervous activity of the child, *Psychological Review*, 1962, 69, pp. 344-354.

Lowell, E., Parental skills and attitudes, including home training, *The Young Deaf Child: Identification and Management*, Acta-Oto-Laryngologica, Supplement No. 206, Stockholm, 1965.

Michaels, J., and Shucman, H., Observations on the psychodynamics of parents of retarded children, *American Journal of Mental Deficiency*, 1962, p. 66.

Neilson, T.G., and Jeffs, M.G., Video tape documentation of an infant education program, *Audiovisual Instruction*, April 1972, pp. 27-29.

Rheingold, H., and Bayley, N., The later effects of an experimental modification of mothering. Stendler (Ed.), in *Readings in Child Behavior & Development*, Harcourt, Brace & World, 1964, pp. 86-92.

Schaefer, E.S., Parents as educators: Evidence from cross-sectional, longitudinal, and intervention research. In W.W. Hartup (Ed.), *The Young Child*, Vol. 2, Washington, D.C.: National Association for the Education of Young Children, 1972.

Shontz, F., Reactions to crisis, *Volta Review*, 1965, Vol. 67, No. 5, pp. 364-370.

Wolpe, Z., Play therapy, psychodrama, and parent counseling. In L. Travis (Ed.), *Handbook of Speech Pathology*, New York, Appleton, 1957.

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Chapter V
Developing Parent Participation

Parents and Professionals

Parents and professionals are developing genuine partnerships today in an increasing number of early childhood education programs. This valuable, productive relationship between equals can be facilitated through active parent involvement in the design and implementation of a program to meet their own needs as well as those of their preschool children.

The role of parent is a third dimension of functioning for a mother or father who is first an individual, later a partner, and finally a parent and family member. Thus, our challenge as educators is to establish a climate in a school setting which enables a parent to reflect and express how he feels about himself, his marriage, and his attitudes and feelings about having a handicapped child. These psychological dimensions of support to parents in an individual and group setting, are the subject of a separate chapter in this manual.

When parents are offered the opportunity in a professional setting to gain insight into the ways that young children learn and the nature of their role in "care giving", three processes are involved. (These processes were labelled by Dr. Murray Reed who is the Supervising Psychologist at the Wilder Child Guidance Clinic in St. Paul, Minnesota.) First, there is *exchange of information* by the partners (teacher and parents) before actual communication begins. This relates to items such as the child's developmental history, the family's social history and certain test results. Second, there is *facilitation of growth in a parent*, who is offered the opportunity to practice new ways of behaving in daily child management. Here, spontaneity, honesty, and openness are essential. One quick way to encourage behavioral changes in a parent is to offer a new role as co-experimenter, observing or teaching a child other than her own. Placement in the "right" group of parents is also useful. The third process is *building a trusting, productive relationship* between parent and teacher which can enable parents to regain their own sense of playfulness and satisfaction in the quality of daily interaction with their preschool child in a home-care setting.

At the same time a parent begins to realize that the quality of home stimulation affects the child's motivation to learn, his expectancy of success and his cognitive style, he should also gain a clear sense, "I don't

have to do it." It is a personal decision. On the other hand, you should be careful lest you get into the vulnerable position where a parent says, "catch", and turns over his child to the school, relinquishing his rightful responsibilities.

Your challenge and charge is to be a person with certain skills and knowledge who appreciates the exchange of information and attitudes for use in personal growth by *both* partners, the parent and the teacher.

Parent participation carries the assumption that there is an interdisciplinary team of professionals and para-professionals available to serve the young, handicapped child and his parents. In a program for preschool hearing-impaired children, for instance, team members might include: coordinator, child development specialist, child psychologist, early childhood educational specialist, educational audiologist, public health representative, social worker, special educator, teacher aide, and volunteer. In a well-established agency, school, or institution these individuals will probably be members of the same professional staff. In an embryonic program, minimally staffed, you will probably have to "import" the services of required resource specialists. No single individual, regardless of the range of competencies possessed, can bear the burden and the responsibility of maintaining active parent participation alone.

Parental Roles that Professional Can Help Define

Parents assume a variety of roles during active participation in the preschool child's educational program. They include:

(1.) *The parent as an individual.* The parent should be encouraged to move toward the solution of personal conflict by expressing his attitudes and feelings about having a handicapped child. This psychological support is the province of the professional psychologist, social worker or psychiatrist.

(2.) *The parent as a student.* Through shared information and support in an individual or group setting, parents can develop realistic expectations based upon knowledge of the behavioral characteristics of young children and the implications of their handicapping condition(s) for realistic home training.

(3.) *The parent as an observer.* Opportunity should be provided for the parent to observe his child individually and in a group situation in order to make some sensitive judgements about his social, intellectual, motoric and communication skills.

(4.) *The parent as reporter.* A parent's ability to share accurate information concerning a child's behavioral changes in all facets of child growth and development should be facilitated through the program.

(5.) *The parent as informal teacher.* This role is assumed when there is an interaction of parent-teacher-child in an experiential activity, and where the parent gradually assumes the lead role under direction. This encourages parental confidence and competence in making use of daily care times for natural listening experiences and spontaneous self-expression.

(6.) *The parent as partner of the schools.* Parental activities may range from service as an advisory board member, volunteer or teacher aide to a lead role in community education and support for expanded preschool services.

Why Parent Participation?

During the vulnerable preschool years, a young child's behavior reflects the emotional climate in his home. The quality of parental responses to his predictable requirements will encourage or limit the child's later development of social skills, emotional stability, and intellectual productivity. (Erikson, 1963)

In summary, parental participation in a preschool educational program requires the assurance of *parent counseling* (emotional support), *parent guidance* (in such areas as behavior management;

linguistic-auditory stimulation) and *parent education* (such as the developmental characteristics of young children).

Assessment of Parental Needs

A teacher's direct observation is probably the most reliable source in assessing a parent's current level of knowledge and unmet needs. The question is, when and under what conditions can the judgment be made most easily?

A weekly developmental log is useful, if the notations are made in it *after* the parent has left an individual guidance or parent-teaching session. The teacher can ask herself such questions as "Is the child prodded or does he run ahead, unassisted?" "Is he a good hearing-aid user?" "How does a parent communicate with the child, and how does he respond?" "What of his behavior?" If both parents were present, did they seem to support each other's questions, expand each other's observations? Did they respond to direct questions by the teacher? What topics were brought up by parents? What was their general mood? To what extent do they participate in group meetings and meet individual appointments?

In addition, you may wish to prepare and encourage parent completion of one or more of the types of rating scales found at the end of this chapter. They can be modified to apply to parents and children with other handicapping conditions than deafness.

In turn, the responses to these kinds of questions become part of the substance of parent-teacher discussions during individual guidance sessions and parent group meetings. The goal is to facilitate a parent's ability to give clear, congruent information about what's happening at home. The following dialogue serves as an illustration.

Parent A: Joe drives me wild.
Leader: All the time? When is it worst? What leads up to it?
Parent B: It just sounds to me like he's got too much energy.
Parent C: He just wants to get hold of everything he sees. You know, figure it out for himself.
Leader: Joe really does have a high energy output. He's very persistent, too. Those are marvelous qualities when they're harnessed during the school years. Don't forget, Joe's only three!
Parent D: Are all kids like that?
Leader: What do you think, mothers?

The ability of parents to look for a deeper level of understanding, to match feelings with words, and to develop new ways of responding to their children can grow if a parent program is built in part upon the findings in a needs assessment study.

Parents and the professional team keep working on the contract, in effect saying, "Let's see, where are we? Who's going to do what next? Where do we go from here?" Thus, there are no orders given to parents, "You must help at home with language," but rather, "It would be helpful if you talked to Sally about her activities of the moment because the hours she's at home are ten times the amount you and she spend with us here in school. That adds up to a great deal of listening experience."

Potential Problems

Active parent participation in the educational program of a handicapped child is the responsibility of the special educator and child development specialist. It is one component of a comprehensive program of guidance, counseling and parent education which requires an interdisciplinary team effort for implementation. Only as a parent is helped to understand and resolve his feelings and attitudes about having a handicapped child, can a natural, affectionate parent-child

relationship develop. This becomes the basis for increased confidence and competence in daily home training and effective child management.

The solo-parent, the parent in a multi-generation family under one roof, and the working parent will require modifications in the timing and content of scheduled involvement to fit their life style, cultural traditions, and working patterns. Other factors enter in to affect parental response to available services.

You may wish to arrange for a new young family to observe other young parents on video-tape or "live" as they engage in an activity with their young child. The direction and reassurance of the teacher then becomes secondary to shared excitement of the young child's response to his parents' auditory and linguistic stimulation.

All parents are discouraged from becoming pseudo-teachers; they should focus instead upon the ways in which a parent can make use of the child's every day experiences in order to encourage language as a natural means of self-expression.

Any teacher who is observing parents carefully can recognize the "selective listener" and the parent who keeps on "shopping" for new cures and more sympathetic ears to listen to her unmet needs. There are also well-educated mothers and fathers who manipulate information from "the literature" to their own advantage without attending to its practical application within the family home. There is the very young parent who may reject the authority of "the establishment" in general. But individuals do change in attitudes and actions if they feel free to make up their own minds and reach their own conclusions about new ways of handling themselves and their children.

There are other factors which make genuine parental participation difficult. They include the mother and father who have transferred from another program and require time to adjust to the values, goals, objectives and activities presently being described to which they are expected to contribute. Perhaps there are parents who have known only one or two handicapped individuals and who may read an unrealistic orientation into the program. There are also interpersonal problems such as marital difficulties which affect the child who needs the security of parental assistance and emotional support.

Once enrolled, the fostering of parental growth through active participation is applicable to *all* mothers and fathers or parent surrogates regardless of their personal circumstances. A parent with little formal education, the bi-lingual parent, the oral and non-oral parent will respond to the challenge if you instill in each the belief that people *can* change. This will require suitable adaptations to insure that every parent is an active participant during group and individual meetings.

In summary, a program of parent participation requires a team effort. It also assumes your familiarity with community resources for referral of problems which lie outside the scope of the educational team to solve.

Parental growth is best assured in a familiar school atmosphere in cooperation with professional staff members who are trusting and trustworthy. Implementation of a family-oriented preschool program which regards all parents as partners offers the promise of enabling a young child to find satisfaction in daily living and fulfillment of his parents' realistic expectations.

Parents as Teachers

Initial educational intervention should include a regular schedule of visits with parent(s) and child, offered either in the family home, school, or demonstration home setting. If the mother works, a relative or baby-sitter is expected to participate. Siblings who are present can be included periodically in the activities or supervised in play by a volunteer or teacher aide.

The one-hour period enables a teacher to observe language and social interaction between parent and child during a shared experiential activity.

Periodic video-taping enables a parent to make certain observations about maternal teaching style and the child's responses. One mother's response was, "Was that *really* me on the first tape? I can hardly remember when I was like that. When Jill glanced away I was talking, and when she looked up at me I was speechless! It was just like a Charlie Chaplin movie." Parents often regain a sense of humor and playfulness in the informal setting offered within their home or in a demonstration room and gradually become more accurate observers and reporters of what is happening. The remainder of the hour offers a parent and teacher the opportunity to describe observed behavioral changes. The topics discussed will range widely, and may be supplemented by quotes from the mother's notebook. Most parents enjoy sharing anecdotes. "When I pretended I was going to sit on Leslie's chair this morning," reported one mother, "she pointed to my fanny and said, 'Too bih (big)' and pointed to the chair, saying 'too 'mall!'" "How logical she is," replied the teacher, "and how great you think it's funny! You care more about what Leslie's trying to tell you than how well she says it, at this point. That's just right!"

A parent's questions should be noted in a teacher's weekly progress report *after* the visit is concluded, along with samples of the child's receptive and expressive language and the highlights of behavior of adult and child. This informal developmental log is a handy reference during the writing of behavioral objectives for each parent and child. Later on, you may consider increasing the interval of time between these visits to maintain their optimal usefulness.

You should plan also for parent involvement in the individual teaching program which must supplement a child's group educational experiences around the age of three years.

Group Meetings

During the year, the opportunity for parents to interact regularly with discussion leaders who represent several disciplines will enhance their benefits from the group learning process. If you accept this premise, are you also offering meeting options for different members of the family? Occasionally, grandparents need a meeting to vent their confusion ("It wasn't that way in my day") away from their children or in-laws. A father may resent being spoon-fed certain information second-hand, limited by his wife's selective recall of conversation during a mothers' meeting. Grouped with other fathers, once a month, with a psychologist or social worker as discussion leader (also a male!), he might be able to sort out his frustrations more easily. Teen-aged siblings are a natural grouping, too. Their search for identity may produce genuine ambivalence of feeling about a young brother or sister who is handicapped. Certainly, this group of peers will appreciate the chance for honest self-expression.

The in-depth exploration of feelings and attitudes about having a handicapped member of the family, whether it be sibling, child or grandchild, is an area reserved primarily for psychological specialists whose pre-service training and professional experiences give the assurance of competent support to troubled family members. The special educator or child development specialist will, of course, respond to direct questions in this area, but generally remains in the central role of coordinator of the parent participation program, arranging for consultant specialists as parental questions and concerns dictate.

At the Whittier Infant-Preschool Family-Oriented Program [A laboratory school of the UNISTAPS Model Demonstration Project for Hearing-Impaired Children, 0-6, and their Parents. (P.L. 90-538 Handicapped Children's Early Education Assistance Act. A First Chance Project.) Project

Director, Winifred H. Northcott, Ph.D.] in Minnesota, no family is kept on a waiting list after the diagnosis of deafness is established. This regional program offers services to all parents and hearing-impaired infants from birth to three and one-half years of age if they reside in any of thirty-two separate school districts which purchase services on a contract basis from the host district, Minneapolis.

Within a few days of enrollment, they are contacted by a PIP (Pop-in-Parent) who explains the program with which the family and child will be involved and responds to parents' questions. Selected parents function in this role and inservice training is provided to describe the parameters within which they must function. Each PIP is matched as far as possible with a new family according to similar factors. For example, if the new enroller is a parent-without-partner, a parent with two hearing-impaired children, a parent who has experienced the trauma of deafness in a young son or daughter following serious illness, then we try to find a similar PIP to visit them. A prescriptive program of individual and group meetings is then initiated by the parent counselor-teacher for each set of parents. The PIP program was inaugurated in 1971.

Now in its fifth year of operation, the Whittier Public School-Infant Program features additional options for parents each year. Two Dreikurs (1964) study groups began this year in response to the wishes of certain parents who believed they knew each other and their children well enough to explore additional ways of arranging learning situations for a child that involve mutual respect and family cooperation. A mother-child nursery is open three mornings a week, and started by staff members two years ago to accommodate children who were diagnosed too late to enter a nursery school for hearing children or who required a more intensive program of special education.

And finally, let's not forget bi-weekly meetings for mothers. Here, a parent feels free to contribute to group discussion, to try and resolve problems ranging from a toddler's chronic hopping out of bed at night to Grandma's taking off a grandson's hearing aid before taking him outdoors.

Gradually, the unwritten "ground rules" for discussion have emerged. (1) Every parent is free to make up her own mind about changing her child-rearing tactics. (2) Agreement is not necessary. (3) Working for clarity *is* necessary. (4) The role of co-experimenter, collaborating to analyze new ways for *one* mother to respond to the behavior problems of another person's child as part of group interaction, is not threatening and all participants benefit. The discussion leaders may range from an audiologist, child development specialist, or pediatrician to a Woman's Lib. representative.

If there is an active regional or state association of parents, it may offer the opportunity for added fellowship, information, and the challenge to work cooperatively with parents in other organizations for the expansion and improvement of services and programs to benefit *all* young and handicapped children. The end product of active parent participation is generally a mother or father who has "stopped shopping" and is comfortable in a multi-faceted role which integrates useful child-centered attention and affection with the parent's own priorities for personal self-expression.

BIBLIOGRAPHY

Calvert, D.R., Olshin, G.M., DeWeerd, M.J., and Berson, M.P., Office of Education describes model projects for young handicapped children. *Exceptional Child*. 1969 (36), 229-248.

Cohen, E.S., Teaching and guidance of preschool deaf children. *Proceedings*, International Congress on Education of the Deaf. Washington, D.C., U.S. Government Printing Office, 1964, 842-847.

Dreikurs, R., *Children, the challenge*. New York, Meredith Press, 1964.

Erikson, E., *Childhood and society*. (2nd ed.) New York, Norton, 1963.

Northcott, W.H., Candidate for intergration: a hearing-impaired child in a regular nursery school. *Young Children*, 1970 (25) 367-380.

Northcott, W.H., Infant education and home training. In L. Connor (ed.) *Speech for the deaf child: knowledge and use*. Alexander Graham Bell Association for the Deaf. Washington, D.C. 1971, 311-334.

Weinstein, G.W., Nursery school with a difference. *Parents*, 1968 (43), 66-69.

APPENDIX

RATING SCALE

1. *A Check-List of Future Discussion Topics.*

   (1 = high interest 5 = little interest)

   e.g. A. Hearing aids: their care and use_____

   B. Drugs, sex and genetic counseling_____.

   C. A Panel of deaf and hard-of-hearing teenagers _____.

2. *Deafness Opinion Scale.*

   (1 = completely agree 3 = neutral 5 = completely disagree)

   e.g. A. A pediatrician is the best person to ask about educating a deaf child.

   B. Hearing aids are O.K. for the hard-of-hearing but are a waste of money for the deaf.

3. *Ideal Condition/Present Status:* A Disparity checklist

   (Self-rating scale. 1 = ability to cope 5 = unprepared)

   e.g. A. It doesn't bother me when people ask if my child is deaf.

   B. My kids drive me wild.

4. *General Terminology Familiarity Scale*

   (1 = complete understanding 5 = no understanding)

   e.g. A. Signal-noise ratio

   B. I.Q.

   C. Speech reception threshold

5. *General Information–Multiple Choice:*

   e.g. A. Most hearing-impaired children are educated in

   (a) residential school classes

   (b) regular school classes

   (c) separate day schools

   (d) special classes in public schools

6. *Value Judgment Scale*

(1 = won't change 3 = might change 5 = will change)

e.g. A. audiogram

B. hearing-aid usage

C. relatives' negative feelings

7. *Parent Information Questionnaire*

(short answer. Please answer as completely as possible in one or two sentences)

e.g. A. What is an experiential activity?

B. Should a hearing-impaired child always wear a hearing aid? Why?

Interdistrict Project for the Hearing-Impaired:
Title III, ESEA. Minneapolis Public Schools.
Anne Seltz, Project Director

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Chapter VI
Planning Your Parent Program

As the number of educational services for preschool children has increased rapidly in the last decade, there has been an increasing awareness of the need to involve parents in these efforts. Research efforts exemplified by the work of Susan Gray (1970) point out that educational efforts in day care centers, nurseries, and Head Start centers must be augmented by involvement with parents. Unless we develop parent programs as a major element of the child devleopment triad, these efforts are destined to only marginal.

As can be seen in the contributions in this monograph, deaf educators have recognized the urgency for involving parents for many years. Recently the federal government has also become more committed to inclusion of parents. The Office of Child Development has recently embarked upon the "Home Start" program focusing primarily on parents as the educators of children.

The U.S. Office of Education has recognized this need by mandating that all programs funded through the Handicapped Children's Early Education Program (P.L. 91-230) must establish an active parent program as one component of a comprehensive project. This mandate by the federal government was not arrived at without due thought.

During the early years of life, a large proportion of what the young and developing child will learn will be learned in the child's home environment. The parent, particularly the child's mother or mother surrogate, will be the primary "teacher". This is true even if the child is enrolled in a substitute care situation such as a day care center. Unless there is planned consistency between the center's educational program and the "educational" experiences taking place in the home environment, much of what is provided in the center program may have little effect on development. Two-way communication between parents and program staff is essential not only for coordination of training between home and center, but also to provide the staff with valuable insight toward the development of the child. For instance, if parents will report their observations of the child's behavior in the home, the center staff can plan for more meaningful activities for the child within the center.

More and more professionals are now acknowledging that parents are also one of the two main consumers of services to children. As consumers who are paying for a service, if not through fees then through public taxes, parents want to participate in planning activities to insure the type of services that they want. The gap between parents' expectations and the services the center provides must become as narrow as possible through cooperation and coordination. Many parents derive social value from group activities that they engage in as part of the center's parent program. Meeting with other parents to provide for the continued good of their children has a great deal of worth in developing the adult's positive feelings about himself.

The major purposes for providing viable parent programs in early childhood education are twofold: (1) to improve the center's effectiveness in providing services to children through their parents and (2) to provide a supportive system for parents to lead a happier and more satisfied life.

Organizing Your Program Components

"O.K.! I understand the importance and need for providing services for parents, but what services should I provide?" Although this is a straight, clear question, the answer can be rather complex. A project or center director should consider the dimensions of the task ahead of him before he initiates activities.

As this monograph demonstrates there are at least four major areas of parent and program needs that you should consider in a precise and systematic manner: emotional support of parents, exchanging information with parents, improving parent-child interactions, and participation of parents in your program. Depending on the needs of your particular set of parents, the purposes of providing activities for each of these areas may be as follows:

Social and Emotional Support. The purpose of activities in this area is twofold: (1) to reduce anxieties caused by guilt feelings and feelings of inadequacy in the family, and (2) to provide socially stimulating activities which increase positive feelings about the family unit as well as the parents' feelings toward themselves as competent parents.

Information Exchange. Activities in this area should lead to: (1) providing parents with an understanding of the rationale, objectives, and activities of the program in which their child is enrolled; (2) developing an understanding of the continuous growth and development of the child as it relates to the child's interactions in the home; and (3) providing the project personnel with background information on the child to facilitate the effectiveness of the center program.

Parent-Child Interaction. Activities in this area are designed to improve the effectiveness of the parents as teachers of the child. The parents will, through the years, be the child's primary source of instruction. Hence, the parents should be capable of providing meaningful interaction with their child to stimulate cognitive, emotional, and social development.

Parent Participation. The purpose of activities in this area is to involve parents in the ongoing activities of the program. The assumption is that by productively utilizing the parent in activities such as a teacher's aide, the parent's feelings of self worth will be enhanced. His or her understanding of children will increase, and a larger repertory of experience and activity for the parent to draw from for interaction with his or her own child will be developed.

In planning for parent programs across these four major areas, follow the sequence of planning stages as presented in Figure I.

Determining Needs of Parents

Before we make decisions as to what services and activities might be helpful to parents we first must determine what needs they have to function as a parent, as a teacher, as an individual. Parents themselves

must be involved in realistically appraising their own needs. Usually needs are perceived more accurately if the needs assessment process is conceptualized and carried out jointly by the parents and professionals. One method of conducting an assessment of parent needs would be to build a series of open-ended questions around the general questions listed in the "Needs" column in Figure I. These questions would comprise the content for an interview with each parent in the program. The information that you secure can then be organized around frequency and priority of various needs, establishing the foundation for your next steps in planning.

Determine Outcome Objectives

Based on the needs of the parents, specific and precise statements should be made as to what outcomes you will expect as a result of your efforts. These statements should be made in terminology that makes it possible for you to determine if you have been successful in reaching the objective. An example of an objective in the area of emotional support would be: by the end of the project year 75% of the parents in the program will demonstrate less anxiety and more acceptance of their child; or, in the area of information exchange: by the end of the project year, parents' knowledge of child development milestones will be significantly increased over previous knowledge.

A mistake that is often made in planning is the establishment of too many objectives. If daily or weekly objectives are established over hundreds of areas, a major danger exists in becoming too engrossed in objectives for the sake of objectives. Outcome objectives should be used as a tool for planning, and must be kept in perspective; they are a means for getting the job done. One or two objectives written for each of the four parent planning areas presented in this monograph should be entirely adequate for administering an efficient program. Due to the nature of your particular program you may even choose not to have objectives in some of these areas.

Establishing Strategies and Activities

Strategies refer to the sets of activities that you select to reach your objectives. The questions listed under the activities column in Figure II illustrate the need to plan your activities very carefully, with your objectives fully in mind. Many individuals begin planning their program by first considering their activities—what they want to see occur day-by-day, and this approach usually results in an ineffective program. The questions about needs and objectives, outlined in Figure II, must first be answered. If you don't know where you are going (objectives), how can you decide how to get there (activities)?

Numerous examples of "how to get there" have been given in the previous chapters of this monograph. They discuss numerous strategies and activities for parent programs across the areas of emotional support, information exchange, parent-child interactions, and parent participation.

Evaluation. Evaluation refers to the process of determining whether or not you accomplished your objectives—a comparison of your objectives with the actual outcome of the project. There are many different evaluation procedures that can be employed; standardized testing, criterion-referenced testing, observing and counting frequency of behaviors, and testimonials are some of the more popular procedures used.

It is essential to establish an evaluation method as part of your overall planning effort at the outset of your project. If evaluation is not considered at that time, you may find that your objectives do not lend themselves to any type of evaluation and it may be too late to effectively change your plan. Or you may find that the activities that you selected are not effective in meeting your objectives established. This may have been avoided if the evaluation proce-

dures were delineated before the activities actually started.

On page 67 is Figure III which is a portion of a planning outline dealing with parent programs, demonstrating how each of the steps discussed above can be placed into a concise and detailed plan. There are many good program planning procedures available in the literature today. The one discussed here is simple and straight-forward and has been used successfully with many new programs.

BIBLIOGRAPHY

Gray, S., and Klaus, R., the early training project: A seventh-year. *Child Development*, 1970, 41, 909-924.

Figure I
STAGES IN PLANNING PARENT PROGRAMS

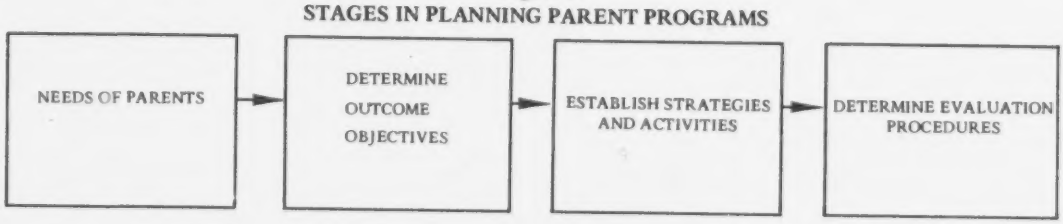

Figure II
PLANNING PARENT PROGRAMS

PROGRAM AREAS	GOALS	OBJECTIVES	ACTIVITIES	EVALUATION
SOCIAL AND EMOTIONAL SUPPORT	What emotional support do parents need?	What changes do I want to occur by the end of the year?	What are the best ways to achieve these objectives?	How successful was I in meeting the objectives?
INFORMATION EXCHANGE	What information do the parents and center staff need from each other?	What information do I want known and by whom at the end of the year?	What are the best ways to provide that information?	How successful was I in meeting the objectives?
PARENT PARTICIPATION	What are the parents' needs to improve their interaction with their children?	What interaction and with what consistency do I want to occur by the end of the year?	What are the best ways to assure that these interactions take place?	How successful was I in meeting the objectives?
PARENT-CHILD INTERACTION	What are the parents' and centers' needs for participation?	What participation is to take place by the end of the year?	What are the best ways to achieve the objectives?	How successful was I in meeting the objectives?

Figure III
PLANNING OUTLINE

Target	Goal	Objectives	Activities	Evaluation Plan
Parents	Involvement of parents in partnership arrangements stressing the needs, strengths, concerns and special knowledge the parents have and utilizing the expertise of the professional.	To reduce anxiety by the end of the second year of the project in 90% of the parents.	Parent group discussion in which parents discuss their efforts to help their child on the problems they have encountered in such effort. A social worker will be assigned and will be available to each parent two hours a week for individual counseling.	Records will be kept listing parents who participate and their time of involvement. Anxiety levels will be measured by a scale (the IPAT 8-Parallel Form Anxiety Battery) as the parents enter the program and at the end of the second year.
		To increase in 80% of the parents an understanding of the programs' objectives and strategies for their children six months after their child is enrolled.	One week after the child is accepted into the program a family conference will be held at which time the program objectives and strategies will be explained. Written reports of child's progress will be sent to parents monthly. Parents report the child's home program to the staff in individual monthly conferences.	The Parent Program Evaluator will develop an instrument that will measure the parents' understanding of the strategies and objectives of their child's program. Each parent will respond to that instrument six months after their child enters the program either in writing or in a parent interview or both.
		To increase the effectiveness of the parents as teachers of their children using home made toys.	Home Visitor visits child's home weekly to demonstrate to parents how simple toys can be made in the home. During the visits parents learn to utilize toys as learning tools.	An anecdotal record is kept of each Home Visit. Parent keeps a record of use of toys during the week. Video tapes of parent-child interaction are taped in the home weekly and critiqued by the Home Visitor and parent.
		To establish and implement three procedures that enable parents to give feedback to the project regarding their child's individual needs and the program in general.	A PARENT FEEDBACK BOX will be installed at the entrance to the center. The parent group will elect two parent representatives to the advisory council. Individual conferences between parents and staff will be scheduled monthly.	Parent coordinator checks PARENT FEEDBACK BOX weekly. Two parent representatives serve on the Advisory Board. A record is kept by Parent Coordinator of individual conferences between parents and staff.

Annotated Bibliography

The following annotations give an overview of areas of concern for those interested in parent involvement in child development centers.

Entries are divided into four areas: emotional support; information exchange; parent child interaction; and, parent participation. Divisions at most are arbitrary as there is a great deal of overlap between areas. Each entry is divided into three sections: SCOPE, CONTENT, MAIN USE.

The focus is parental involvement in early education programs, but most of the references would be applicable to other programs as well.

Emotional Support

Davis, Fred, *Passage Through Crisis: Polio Victims and Their Families.* Indianapolis: Bobbs-Merrill, 1963, 195 pp.

SCOPE: A sociological inquiry into the problems of families when a child contracts polio. This is a naturalistic study of 14 families as they go through this crisis.

CONTENT: This is a good presentation of the "identity stresses" of both the child and the family. Discussed are the various perceptual modifications which take place when there is the realization that something is wrong. Other issues dealt with are "the shift in family image, the problem of ambiguous communications from the doctor; expectations for improvement and adjustment strategies of the parents."

MAIN USE: Although this study is specifically about the crisis situation which arises because of polio, much of what is said can be generalized to other crisis situations. The sociological framework from which Davis works is a good one for looking at this kind of problem. Especially relevant to the parents of a handicapped child are his ideas concerning the problems in the exchanges of two subsystems of society (i.e., the professional and the family.)

Goffman, Erving, *Stigma: Notes on the Management of Spoiled Identity.* Englewood Cliffs, N.J., Prentice Hall, Inc., 1963. 147 pp.

SCOPE: A discussion of stigmatized individuals: persons who do not (or can not) conform to standards which society calls normal. Deals with various aspects of a stigma (stigma = a discrepancy between virtual and actual social identity.)

CONTENT: Some of the topics are: the way society provides the means for categorizing people; the important distinction between being discredited and being discreditable; how a stigma can be used as a "crutch" for secondary gains; how tension is managed if the stigma is easily perceived (by others); how information is managed if it is not apparent; the importance of the perceptibility and the obtrusiveness of a stigma.

MAIN USE: Can give an interesting perspective to anyone who must deal with stigma. It is a book which confronts us with the obvious that we had not realized.

Noland, Robert, ed. *Counseling Parents of the Mentally Retarded–A Source book.* Springhill, Ill.: Charles C. Thomas, 1970, 404 pp.

SCOPE: This book of readings deals with approaches, problems, and concerns of parents with mentally retarded children. The focus is effective counseling of parents of retarded children.

CONTENT:
Part I – Parent's Feeling About Their Mentally Retarded Children
Part II – The Initial Informing Interview with the Parents
Part III – Group Counseling with Parents of Retarded Children
Part IV – Family Casework and Child Placement
Part V – Pastoral Counseling
Part VI – Genetic Counseling

MAIN USE: Information for professionals who counsel parents of mentally retarded children.

Love, Harold D., *Parental Attitudes Toward Exceptional Children.* Springfield, Illinois, Charles C. Thomas, 1970, 167 pp.

SCOPE: A fairly simple book on parental attitudes and reactions to exceptional children.

CONTENT: There is an opening chapter which helps to answer the question "Who are the Exceptional Children?" The author draws on some of the research that has been conducted in the area of attitudes. There are separate chapters on attitudes toward the mentally retarded, physically handicapped, gifted, emotionally disturbed, deaf and blind, as well as the child with other special health problems. Some of the specific issues dealt with are advice on social and physical development of the child, a discussion on the question of institutionalization, and some advice on problems with siblings.

MAIN USE: A book to help educators and other professionals analyze parental attitudes; and to help counsel parents who have exceptional children.

Schlesinger, Hilde S., and Meadow, Kathryn, P., *Sound and Sign: Childhood Deafness and Mental Health.* Berkeley, California: University of California Press, 1972.

SCOPE: A collaborative psycho-social study of deafness. Different aspects of adaptive and maladaptive patterns of deaf individuals are illuminated.

CONTENT: A theoretical framework, based on the work of Erik Erikson is presented for viewing the developmental problems associated with deafness. Research findings on the impact of deafness on mother-child interactions, on early language acquisition (spoken and manual), on behavioral disorders are presented. A chapter on a comprehensive program of mental services for children and adults indicates that some of the developmental problems of deafness are amenable to change through early intervention.

MAIN USE: A useful handbook for parents and professionals interested in a closer approximation between potential and achievement for deaf child and adult. The focus on the developmental tasks and how they can be facilitated should prove useful to programs with early parental involvement and participation. Although the focus is on deaf children, the implications and framework can be extended to other handicapped and stigmatized groups as well.

Wolfensberget, Wolf and Kurtz, Richard A., (editors) *Management of the Family of the Mentally Retarded*, Follett Educational Corporation, 1969, 542 pp.

SCOPE: This is a book of readings on the management of the family (management = the entry of a person or organization in an official or widely sanctioned capacity into lives of the members of the family) of the mentally retarded child.

CONTENT: The editors list some criteria for selection of these articles. Three of these are (1) contributions which are likely to enhance practical management competency; (2) to bring together sources that have come to be considered classics; and, (3) to provide a sense of history and continuity. Sections include: "The Challenges and Demands of Family Management", "Parental Dynamics Relative to Management", "General Principles of Management and Counseling", "Special Management Techniques", as well as many other topics.

MAIN USE: To facilitate the learning process of family managers. This book will help to give professionals a framework from within which to work with parents.

Parent Participation

Adair, Thelman, and Eckstein, Esther. *Parents and The Day Care Center*. 281 Park Ave. S.N.Y. 10010. Federation of Protestant Welfare Agencies. 1969. 36 pp.

SCOPE: The purpose of this guide is to offer suggestions to the director on "how to begin parent participation, how to keep it going, and how to expand it . . ." (6) in the day care setting.

CONTENT: Parent participation is discussed in terms of parents as "actual and potential assets, capable of helping the center toward a mutual widening of horizons." (7) Attention is given to developing a parent group profile, a community profile, and channels of communication for more accurate assessment of parental needs for involvement. The last pages are devoted to evaluation questions.

MAIN USE: This booklet is a very useful guide for planning parent involvement. It is easy to follow and the form could be utilized by most types of programs.

Calvert, Donald R. Dimensions of family involvement in early childhood education. *Exceptional Children*, 655-659.

SCOPE: Overview of dimensions of parent programs including who, what, why, when, where, and how.

CONTENT: Who: encouragement of as many family members as possible to participate; what: learning, working with children's planning and policy making, disseminating information about the program, assisting in administering the total program, evaluating the program; why: family member to help himself to help the program, to help the child; when: periods of involvement and amount of time spent; how: inducing family member participation.

MAIN USE: For directors and teachers of day care center agreeable of the handicapped as guidelines for delineation of dimensions involved.

Gordon, Ira J., *Parent Involvement in Compensatory Education.* University of Illinois Press: ERIC Clearinghouse on Early Childhood Education, 1968, 87 pp.

SCOPE: This monograph explores the role of parent involvement in compensatory education. Involvement is viewed at different levels ranging from observation to control of school system and school board. Rights of parents are pointed out.

CONTENT: The first section discusses the family as an agent of socialization and education. Examples are given of parent participation in university research programs and school and community programs. The final section discusses the implication of this information for parent programs.

MAIN USE: This monograph would be useful to any person planning a parent program because it sensitizes the reader to the parents' point of view. The emphasis is planning with parents and not *for* parents.

Gordon, Ira. "Stimulation via Parent Education." *Children* Vol. 16, No. 2. March-April, 1969. pp. 57-59.

SCOPE: A brief description of Gordon's program—"Use of women from disadvantaged neighborhoods to teach indigent mothers with infants and young children how to stimulate their children's development". (57)

CONTENT: Discusses research design, parent educators' training, evaluation and research results of Gordon's program.

MAIN USE: Introduction to Gordon's program. Basis for deciding if more information on Gordon's program would be useful.

Green, John S., *Parent Education Handbook*, Chattanooga, Tenn.: Tenn. Re-Education Program, Tenn. Dept. of Mental Health, Children's Re-Education Center, 34 pp.

SCOPE: Handbook designed as a guide for individuals who are interested in offering courses in parent-education. Based on Gordon's *Parent Effectiveness Training*.

CONTENT: Discusses functions of group leader; structure of the parent group; areas for group discussion such as defining behaviors; contracting, punishment; teaching responsibility; communications in the family.

MAIN USE: To use as content for a 4-6 weeks course to train leaders for parent-education groups. May be followed up by course in *Parent Effectiveness Training*.

Horton, Della. "A training program for mothers." Nashville: DARCEE George Peabody College, 5 pp.

SCOPE: This article describes the training program for mothers participating in the DARCEE classroom.

CONTENT: The training program for mothers is described in the following phases: (1) Orientation; (2) Demonstration and role play; (3) Classroom participation with minimal structure; and, (4) Classroom participation, instructional.

MAIN USE: This procedure is a useful guide to train parents to participate actively in the classroom. The training program is geared for low income mothers of preschool children.

Kamara, Barbara, *Developing Parent Power in the Head Start Program.* LINC Child Development Training Center, Greensboro, N.C. April 14, 1971, 13 pp.

SCOPE: This speech gives insight into the difficulties that poor people have in coping with a life of poverty. It presents parent involvement from a parents' point of view.

CONTENT: A sensitive personal account of what it means to live in poverty. It then discusses features in a poverty environment. Parent involvement is discussed in terms of levels of involvement—which relate to parent power.

MAIN USE: The affect of this speech makes it appropriate reading for any person working with poverty families, and interested in a parent program with power.

Lazar, Joyce and Chapman, Judith. "A Review of the Present Status and Future Research Needs of Programs to Develop Parenting Skills." Washington, D.C.: Social Research Group, The George Washington University. 2401 Virginia Avenue, N.W. April, 1972. 203 pp.

SCOPE: This is a State of the Arts paper on completed and ongoing research in parent education. It was prepared at a request from the Office of Child Development by the Staff of the Information Secretariat. It is based on a review of the literature of recent studies involving parent education.

CONTENT: A history of parent education is given. Abstracts of parent programs are presented in the following order: *parent-oriented programs* ("offer some kind of tutorial or group experience for parents"); *child-oriented programs* ("enrichment activities are presented almost exclusively to the child—parents may or may not observe and may be expected to carry out continuing activities with the child"); *omnibus program* ("provide more than one pattern of service to children and families and may aim enrichment efforts simultaneously") (5,6). Studies are described and analyzed to identify available findings in the area of parent education. The final

chapter contains an overall summary and issues, needs, and gaps are identified and recommendations for future research indicated.

MAIN USE: An excellent comprehensive source of information on parent education research. Could be utilized to plan parent programs and to identify useful elements in other parent projects.

Report of the New Jersey State Department of Education Work-Study Conferences on Parent-Implemented Follow Through Programs. *Planning Parent-Implemented Programs—A Guide for Parents, Schools, and Communities.* Trenton, New Jersey 08625: State of New Jersey Dept. of Ed., Office of Federal Assistance Programs, 225 W. State Street, 1969, 50 pp.

SCOPE: The focus of this paper is parent-implemented Follow Through Programs. Stressed is the "decision-making functions of parents and the role of professionals in a school program committed to parent-school-community involvement." (p. 37)

CONTENT: Rationale for choosing a parent implemented Follow-Through program; legal aspects; staff training; special considerations; strategies for securing community participation and support; and the meaning of parent-implementation (joint home-school responsibility and mutuality of goals.)

MAIN USE: Useful for any group that is interested in sharing the responsibilities and privileges of educational decision-making with parents.

Rood, Larry A., *Parents and Teachers Together: A Training Manual for Parent Involvement in Head Start Centers.* Washington, D.C.: Gryphen House, 1971, 84 pp.

SCOPE: Manual to help groups of parents and staff in a child development center to work together in developing the type of program they want for their center and to implement that program on a day to day basis.

CONTENT: Provides training experiences for parents and teachers in the following areas of group interactions: building a relaxed informal group, individual contributions, communications, problem solving, leadership styles, decision and policy-making for the center. Also, methods to evaluate the training.

MAIN USE: To be used in child development programs by person responsible for parent involvement. Excellent materials for training parents and staff.

Project Head Start. *Parent Involvement–A Workbook of Training Tips for Head Start Staff.* Washington, D.C. 20201: U.S. Dept. of Health, Ed., and Welfare, 1968, 91 pp.

SCOPE: This workbook is a guide to developing meaningful parent involvement by use of parents as resources in all programming aspects. Focus is parent involvement the way parents want it—not what staff wants for parents.

CONTENT:
I. Head Start Staff and the parent involvement process.
II. Involving parents in advisory structures.
III. Involving parents as paid workers and volunteers.
IV. Involving parents in self, family and community development.
V. Parent Involvement Evaluation Guides.
VI. Tips to staff on Involving Parents and Materials from the field.
VII. Resources.

MAIN USE: Developed for Head Start staff but many of the ideas could be adapted to other settings by people who are interested in developing parent power.

Information Exchange

Auerbach, Aline B., (in cooperation with Child Study Association of America) *Parents Learn Through Group Discussion: Principles and Practices of Parent Group Education,* New York: John Wiley and Sons, Inc., 1968. 358 pp.

SCOPE: A guide which presents methods that have been developed to meet the needs of parents in educational discussion groups. The techniques which are presented are based on a philosophy with specific educational goals.

CONTENT: Details for planning and carrying through continuous small group discussions under professional-skilled leadership. Good discussion of rationale for parent group education, description of what it is (in contrast with Formal Academic Teaching; Group Counseling, Group Dynamics, Group Therapy), the meaning of group interaction for the learning of the group; the role of the leader, and group education for special situations (such as for parents of handicapped children.)

MAIN USE: This book is mainly for professionals who need some guidelines for conducting groups for educating parents. It should be a helpful guide for the conducting of groups for the purpose of educating parents about handicapping conditions of children.

Becker, Wesley C. *Parents are teachers, a child management program*. Champaign, Ill., 61820, Research Press Co., P.O. Box 3377 County Fair Station, 1971. 194 pp.

SCOPE: Designed to help parents learn to be more effective teachers of their children. Program shows parents how to systematically use consequences to teach children in positive ways what they need to learn to become effective people.

CONTENT:

I. Consequences: Reinforcers and punishers
   When to reinforce
   Why parents goof: the criticism trap.
   How to reinforce
II. Punishment: When to, How to, and Why not to usually
   Reasons, Rules and Reminders
   Your child's personality and you
   Answers to exercises

MAIN USE: To teach child management to parents in a group setting. Useful for parents of handicapped children.

Brim, Orville G. *Education for Child Rearing*, N.Y.: Free Press, 1959, 362 pp. $2.95.

SCOPE: The focus of this book is parent education as defined by the Child Study Association of America. "To make the parent more conscious of his role performance, to make him more autonomous and creative, to improve his independent judgement, to increase the rationality of the parent's role performance" (10).

CONTENT: This book of readings covers all aspects of parent education: nature of parent education; influence of parent on child; cause of parent behavior; aims and clientele of parent education; content; methods; training and evaluation.

MAIN USE: This is most applicable to large-scale parent education programs. The research is dated. However, the chapters "aims of parent education", and "clientele of parent education" are useful to consider for guidelines to developing information exchange programs.

Galloway, Charles, and Galloway, Kay C. *Parent Groups with a Focus on Precise Behavior Management*, Nashville, Tennessee: Institute on Mental Retardation and Intellectual Development, Peabody College, Volume II, No. 1, 1970, 38 pp.

SCOPE: This monograph explains procedures for setting up a parent group to instruct parents of retarded children to use the tools of precision teaching in dealing with behavior problems at home.

CONTENT: The author discusses strategies for developing parent groups; instruction of parents to methods of precision teaching; some examples of parent projects; and some attempt to answer the question: "Why do some parents participate and others don't?".

MAIN USE: This material can be used as a basis for teaching parents how to record baseline data on their child's behavior, intervene, and see if the rate of the behavior changes. The method could be utilized by most parents of retarded children.

Gordon, Thomas. *Parent Effectiveness Training: The "No-Lose" Program for Raising Responsible Children*, New York: Peter W. Hyden, Inc., 1971, 338 pp.

SCOPE: Book describes complete model for effective parent-child relationships. How to bring discipline into the home through effective management of conflict.

CONTENT: Discusses such areas as: Parents as Persons, Active Listening, Putting "I-Messages" to Work, Parental Power, "No-Lose" Method to Solve Conflicts, and, exercises to facilitate using the model.

MAIN USE: Method of solving conflicts to be used by parents and children. Serves as a basis for an 8-week course in Parent Effectiveness Training.

Kirk, Samuel A., Karnes, Merle B., and Kirk, Winifred D., *You and Your Retarded Child.* Palo Alto, California: Pacific Books, 1968, 164 pp. (First Edition, 1955).

SCOPE: A manual for parents of retarded children. It provides both information and instructional materials.

CONTENT: Various topics which should be of interest to parents with a retarded child are discussed. There is a chapter on levels of retardation and a discussion to help answer the question, "How retarded is my child?" There is an extensive checklist of "normal" child development with which parents can compare their own child's development. There are good chapters dealing with self-help skills, playing, talking and emotional adjustment.

MAIN USE: Can be used as a manual to be given to parents of a retarded child. It could be useful as an adjunct to a project self-help skills training program. It would help parents understand the process of teaching such things as self-help skills.

Larsen, Lawrence, and Bricker, Wm. *A Manual for Parents and Teachers of Severely and Moderately Retarded Children.* Nashville, Tennessee: IMRID Papers and Reports, Peabody College, Volume V, No. 22, 1968, 138 pp.

SCOPE: The premise of this manual is that the behavior of the mentally retarded child can be changed. The sample activities are designed to aid parents and teachers in this behavior change.

CONTENT: Part I is oriented toward the methods and principles of behavior modification. Examples of techniques are included. Part II is aimed at specifying in detail some of the activities to which these methods can be applied. Some sample activities include: sitting quietly, playing with toys, various self-help skills, and talking in sentences. The appendices include: materials, reinforcers, sample forms for pretest and posttest and application to blind and deaf children.

MAIN USE: This manual would be very useful to parents and teachers of retarded children that want to change the child's behavior. Dr. Verna Hart suggests ways the information can be modified for use with blind or deaf children. Could be used in parent groups setting.

Ora, John P. "Home Programs", RIP Oppositional Child Technicians, Nashville, Tenn. George Peabody College, 1971. 30 pp.

SCOPE: Behavior modification programs to be used in the home by parents of oppositional children.

CONTENT: Applies behavior modification approach to potential problem areas: bathtime, bedtime, eating, yard, telephone, temper tantrums, and toilet training. Includes baseline instructions and step by step procedures.

MAIN USE: By parents of oppositional children under *supervision* by person familiar with behavior modification and its ramifications. Appropriate for use in parent group.

Patterson, Gerald R., and Gullion, M. Elizabeth. *Living with Children:* New Methods for Parents and Teachers. Champaign, Illinois: Research Press. 1968. 120 pp.

SCOPE: Traces in detail the manner in which the parent teaches the child and the child teaches the parent. Social learning approach. Introduction to behavior modification.

CONTENT: First section deals with how parents and children learn—discusses reinforcers—accidental training and retraining. Second section deals with changing undesirable behavior such as child who fights too often, overly active child, dependent, frightened, withdrawn child.

MAIN USE: Programmed instruction approach is useful to teach behavior modification to parents in groups. Techniques applicable to parents of handicapped children.

Parent Child Interaction

Barsch, Ray H., *The Parent of the Handicapped Child: The Study of Child-Rearing Practices.* Springfield, Illinois: Charles C. Thomas, 1968, 435 pp.

SCOPE: A study of the child-rearing practices of parents of a handicapped child. In many ways it parallels the study done by Dr. Robert Sears on parents of "normal" children.

CONTENT: The purpose of this study was to see if there are differences in child-rearing practices for five different populations of handicapping conditions. These different groups were: (1) organic; (2) blind; (3) cerebral palsy; (4) mongoloid; and, (5) deaf. The data came from in-depth clinical interviews and a series of group administered questionnaires. There were 177 complete

cases for study, numerous aspects of child-rearing were examined. There was found to be a general tendency towards similarity in child-rearing practices among the five groups with scattered evidence of variations which might be attributed to the particular nature of the child's handicap.

MAIN USE: For anyone interested in focusing on child-rearing, especially those who are working with parents of handicapped children. This book could be a help in giving a general background for evaluation of parent programs.

Brown, Carolyn. *For Beginning-to-be-Teachers of Beginning-to-be-Students.* Nashville, Tenn.: DARCEE, George Peabody College for Teachers, 1971, 72 pp.

SCOPE: Illustrated booklet gives helpful information for adults working in a classroom on all aspects of teaching skills and "what a teacher should know".

CONTENT: Practical suggestions on content and methods of teaching: child behavior, lesson planning, discipline, parents, and evaluation. Easy-to-read and delightfully illustrated.

MAIN USE: Teachers, parents, and other adults who are being oriented to working in the classroom, in home-visitor programs, etc. Supplement to a training program.

Cole, Ann, et al. *Recipes for Fun.* Winnetta, Ill.: Parents as Resources, 1970, 42 pp.

SCOPE: This booklet is written on the premise that parents are key figures in developing their child's intelligence, creativity, and awareness of his world. It points out to parents things they can do to utilize this potential.

CONTENTS: The booklet is divided into hints (what to save, what to buy), make-believe activities, music and rhythm; making things, exploring, learning games and party fun. It emphasizes using articles already available in the home and learning by doing.

MAIN USE: Can be used in a workshop approach to show parents how to increase quality of their interaction with their child through games. Useful to parents of all types of children. An accompanying manual *Workshop Procedures* has been designed to translate the ideas found in *Recipes* into a workshop format for training parents.

Farber, Bernard, *Mental Retardation–Its Social Context and Social Consequences.* Boston: Houghton Mifflin, 1968, 287 pp.

SCOPE: A book on the social aspects of mental retardation. Farber regards the mentally retarded as a surplus population because of institutional selection processes in our society. There are important implications which arise from being a part of a surplus population.

CONTENT: Some of the topics discussed are: techniques for determining prevalence, social factors in prevalence, consequences of labeling persons as mentally retarded, the effects of and on the family, parent organizations, and the structure of residential institutions.

MAIN USE: For professionals who work with mentally retarded children and their parents. This book has large scale implications, for Farber says that the major problems associated with mental retardation will only be solved when personal growth rather than institutional efficiency is the major goal in our society.

Forrester, Bettye J., et al. *Home Visiting with Mothers and Infants.* Nashville, Tenn. DARCEE, George Peabody College, 1971, 100 pp.

SCOPE: Presents information about a home visiting strategy for mothers and infants and home visitor practices to modify mothers' interactions with their infants.

CONTENT: Range from general, *a priori*, considerations to specific, empirical findings. Discusses considerations that underlie the home visiting approach; overall process of planning, implementation, and evaluation; how home visiting proceeds; and suggestions, observations, and evaluation of home visits.

MAIN USE: Anyone interested in implementing a home visitor program. Is geared toward use with low income families.

Forrester, Bettye J., et al., *Materials for Infant Development.* Nashville, Tenn.: DARCEE, George Peabody College for Teachers, 1971, 83 pp.

SCOPE: Manual discusses materials that promote infant growth and development. These materials are used in the DARCEE home-visiting program.

Gordon, Ira J., and Lally, Ronald. *Intellectual Stimulation for Infants and Toddlers.* Gainesville, Florida: Institute for the Development of Human Resources, College of Education, University of Florida, 1969, 95 pp.

SCOPE: This manual contains learning games for mothers to use with their infants and toddlers. Games are presented as means for intellectual stimulation of infants by mothers and fathers.

CONTENT: A brief introduction presents to mothers, in non-technical language, the value of "learning games." The major part of the manual is "games", presented in eight series, arranged according to development. Each game is illustrated and is explained in the following categories: position (mother and baby); action (what mother is supposed to do); arm (what the baby is to do); and purpose (why is this game useful?). The appendix includes suggestions for making toys.

MAIN USE: This manual could be used in parent education groups; home visiting or any program that seeks to improve the quality of parent child interaction. The format of this manual lends itself to use with parents of diverse educational levels.

CONTENT: Chapters include: areas of early development and provisions for the infant; details of materials field-tested in homes (how to make, purpose, how to use); and how materials are related to the DARCEE home-visiting program.

MAIN USE: Used by home visitors in planning their visits with parents and children, and by parents to develop their own materials.

Giesy, Rosemary (Ed.), *A Guide for Home Visitors.* Nashville, Tennessee: DARCEE, George Peabody College, 1970, 192 pp.

SCOPE: This guide provides information for persons who are training to be home visitors. It was developed for use with paraprofessionals in the homes of low-income children.

CONTENT: Topics discussed include: introduction to the home visiting approach, living conditions that influence learning, how home visiting is done, and recording home visits. The appendix includes suggested activities for home visits, and a sample unit.

MAIN USE: This manual is designed to be used as a training guide for home visitors. It is geared for use with paraprofessionals.

Northcott, Winifred H., Ed. *Curriculum Guide–Hearing Impaired Children–Birth to Three Years–and Their Parents.* St. Paul, Minnesota; UNISTAPS, 1971, 164 pp. (Available, Alexander Graham Bell Association for the Deaf, 1537 35th St., N.W., Washington, D.C. 20007)

SCOPE: Guide presents a curriculum for hearing impaired children, birth through three years of age.

CONTENT: Explains components of a comprehensive infant program for hearing impaired children. Includes descriptions of behavioral objectives for children with normal hearing and normal developmental patterns within specified age groups. Examples of experiential activities to use in a parent-teaching program are also included.

MAIN USE: Curriculum to be used by teachers and parents of hearing impaired children either in school or in a home setting.

Ross, Alan O., *The Exceptional Child in the Family*, New York: Grune & Stratton, Inc., 1964, 230 pp.

SCOPE: An in-depth book on the subject of the family as a dynamic system of interacting

Ross, Alan O., *The Exceptional Child in the Family*, New York: Grune & Stratton, Inc., 1964, 230 pp.

SCOPE: An in-depth book on the subject of the family as a dynamic system of interacting individual personalities. The author specifically deals with the problems of the family of an exceptional child.

CONTENT: The book begins with a detailed discussion of much of the research that has been done on the dynamics of family interaction. Operating on a set of basic principles about the family, the author relates these to the special problems of the family of an exceptional child. There are chapters on parental reactions, counseling parents, the mentally retarded child, the child with sensory defector physical handicap, the emotionally disturbed and mentally ill child, the gifted child, and the adopted child in the family. There is also a case study and short annotated bibliography.

MAIN USE: This book should help professional people to understand the special situation of the interaction in a family with an exceptional child.

Schaefer, Earl S., Parents as educators: evidence from cross-sectional, longitudinal, and intervention research. *The Young Child*, ed. by W.W. Hartup, Volume 2. Washington, D.C.: National Association for the Education of Young Children, 1972.

SCOPE: Rationale for parent-centered programs.

CONTENT: Reports research results in the following areas: conceptualization of parent behavior, intro-family resemblance, early emergency of levels of intelligence, studies of children in institutions and adoptive homes, cross-sectional studies, longitudinal studies, and intervention research.

MAIN USE: Reference for establishing a rationale for parent programs. It presents research findings on which to base the rationale.

Segner, Leslie and Patterson, Charlotte. *Ways to Help Babies Grow and Learn: Activities for Infant Education*, Denver Colorado: World Press, 1970, 49 pp.

SCOPE: A guide to helping the infant and toddler learn skills which prepare them for successful school experiences.

CONTENT: The material is divided into four learning areas: language development, personal-social development, fine motor development, and gross motor development. Activities are grouped separately for infants (to 12 months) and toddlers (to 3 years) and are arranged in order of difficulty. An appendix of toys and games is also included.

MAIN USE: This manual could be utilized by parents or teachers to develop and capitalize on parent-child interaction. The format is easy to follow. Activities could be used in a home visitor program.

This monograph is distributed pursuant to a grant from the Office of Education, U.S. Department of Health, Education, and Welfare. Grantees undertaking such projects under government sponsorship are encouraged to express freely their judgment in professional and technical matters. Points of view or opinions do not, therefore, necessarily represent official Office of Education position or policy.

CUT HERE

FEEDBACK

To help improve delivery of assistance in the area of parent involvement we would like some feedback on this monograph. Please fill in this questionnaire and return it to us.

Name of Project _____

1. The most useful portion of this monograph is

   _____ Emotional support
   _____ Information exchange
   _____ Parent Participation
   _____ Parent-child interaction
   _____ Planning your parent program
   _____ The child development triad

2. It would have been useful to include the following additional areas _____

3. I was already familiar with

   _____ a large portion of this material
   _____ emotional support
   _____ information exchange
   _____ parent participation
   _____ parent-child interaction
   _____ annotated bibliography
   _____ planning your parent program
   _____ child development triad

4. This is the first of a planned series of monographs dealing with various areas. Therefore, we are interested in your frank opinion as to its usefulness and effectiveness.

   In general my opinion of the monograph is _____

   _____

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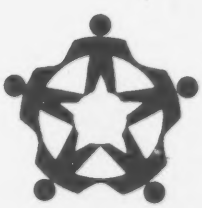

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